| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878<br><br>Based on interview and record review, the facility failed to obtain an informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) from the resident or their responsible party (a person delegated to make medical decisions for the resident in the event they are unable to do so) prior to application of a self-released seat belt for one of three sampled residents (Resident 1).<br><br>This deficient practice violated the resident's right to be informed of and participate in the resident's treatment.<br><br>Findings:<br><br>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 3/27/2024 and readmitted the resident on 6/7/2024 with diagnoses including muscle weakness, type 2 diabetes mellitus (DM- a disease that occurs when your blood glucose, also called blood sugar, is too high), and obsessive-compulsive behavior (a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts [obsessions], engages in repetitive behaviors [compulsions], or both). The Admission Record indicated the Primary Decision Maker was Responsible Party 1 (RP 1).<br><br>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/23/2024, indicated Resident 1 was moderately impaired (decision making poor, requires cues and supervision). The MDS indicated Resident 1 required moderate assistance with showering and requires touching assistance with oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and with personal hygiene.<br><br>A review of Resident 1's Care Plan, developed on 5/23/2024 indicated Resident 1 was at risk for fall and or injuries secondary to poor safety awareness and actual fall on 5/23/2024. The interventions included to bring the resident to activities, have CNA take the resident to the bathroom as indicated and before bringing to activities and if in wheelchair place at the table and lock wheelchair near activity department.<br><br>A review of Resident 1's Medication Administration Record (MAR- a report detailing the drugs administered to a patient by a healthcare professional at a treatment facility) dated 6/23/2024 for insulin regular human injection solution inject as per sliding scale, indicated Resident 1 ' s blood sugar was 315 and was given 8 units of insulin by Licensed Vocational Nurse 2 (LVN 2) on 6/23/2024.<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident 1's Fall Risk assessment dated [DATE] indicated Resident 1 had a fall risk score of 24 (a score of 18 or more is High Risk).<br><br>A review of Resident 1's Physician Orders dated 6/23/2024 at 5 p.m. indicated an order for self-release seat belt (SRSB) while in wheelchair for positioning. Informed consent obtained by medical doctor from RP after explanation of risk and benefits. Ensure equipment is in place and functioning properly.<br><br>A review of Resident 1's Restraint-Physical dated 6/23/2024 at 5 p.m. indicated Resident 1 had unsteady gait, frequent falls and was agitated, and unable to be redirected. The summary indicated to use self-release belt while in wheelchair for proper positioning secondary to leaning forward. The date and time of first application indicated 6/23/2024 at 5 p.m., the doctor was notified on 6/23/2024 at 5 p.m. and Family Member 1 (FM 1) was notified on 6/23/2024 (no time indicated).<br><br>A review of Resident 1's Physician Orders dated 6/23/2024 at 8 p.m. indicated to discontinue use of self-release seat belt (SRSB) while in wheelchair for positioning. Informed consent obtained by medical doctor from RP after explanation of risk and benefits. Ensure equipment is in place and functioning properly, per RP request.<br><br>During an interview on 6/27/2024 at 11:42 a.m., with FM 1, FM 1 stated the Director of Nursing (DON) spoke to her recently (unsure of the date and time) and the DON stated that Resident 1 was improperly restrained and (the DON) wanted Resident 1 to use a lap buddy, to which RP 1 agreed to. FM 1 stated the facility did not obtain FM 1 and RP 1 ' s consent before using the self-release seat belt on Resident 1 on 6/23/2024. FM 1 stated she came into the facility on [DATE] and observed Resident 1 with a restraint.<br><br>During an interview on 6/27/2024 at 2 p.m. with the DON, the DON stated RP 1 had a concern regarding the use of self- release belt on 6/23/2024. The DON stated Registered Nurse 1 (RN 1) called the doctor on 6/23/2024 around 5 p.m. because Resident 1 was agitated, and staff was not able to redirect Resident 1. The DON stated Resident 1's family was not notified of Resident 1 using the self-release belt. The DON stated the self-release belt was applied on Resident 1 on 6/23/2024 at 5 p.m. and was discontinued on 6/23/2024 at 8 p.m. The DON stated the resident's family must be notified if there is an emergent situation that requires the use of a restraint.<br><br>During an interview on 6/27/2024 at 2:45 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated on 6/23/204 around 4:30 p.m. LVN 2 checked Resident 1's blood sugar and it was low (cannot recall the level) and offered Resident 1 orange juice. LVN 2 stated Resident 1 was leaning forward, with an unsteady gait while the resident was sitting in the wheelchair, due to low blood sugar and the resident kept getting up to go to the bathroom without assistance. LVN 2 stated a CNA was assigned to Resident 1 to monitor and to remind the resident to not get up without assistance, but the CNA had to leave to assist other residents with their meals and that is when LVN 2 asked Registered Nurse 1 (RN 1) for an order for the self-release belt. LVN 2 stated the self-release belt was applied to Resident 1 around on 6/23/2024 at 5 p.m., but she did not call RP 1 or the resident ' s family for a consent. LVN 2 stated FM 1 came to facility around 6:30 p.m. and the self-release belt was taken off around 7:30 p.m. or 8 p.m. LVN 2 stated the resident ' s family should have been informed prior to application of the restraint so they can consent or refuse its use.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/27/2024 at 3:26 p.m. with RN 1, RN 1 stated on 6/23/2024 at 5 p.m. LVN 2 told RN 1 that Resident 1 was agitated, kept going to the bathroom and was unable to be redirected. RN 1 stated, LVN 2 was afraid Resident 1 would fall so RN 1 stated she called the doctor and got an order to apply the self-release belt to Resident 1. 1 RN 1 stated FM 1 came between 6:30 pm and 7 p.m. and stated to LVN 2 FM 1 did not want the self-release belt on Resident 1. RN 1 stated she informed the doctor that FM 1 refused the use of the self-release belt, and the doctor discontinued the order. RN 1 stated the self-release belt was discontinued around 8 p.m. RN 1 stated she did not obtain consent from Resident 1's RP or family member prior to application of the self-release belt to Resident 1.<br><br>During a concurrent record review and interview on 6/27/2024 at 3:50 p.m. with the DON, Resident 1 ' s Physician Orders dated 6/23/2024 at 5 p.m. and the facility policy Physical Restraint were reviewed. The DON stated the seat release bealt was ordered by the doctor for positioning. The DON stated the informed consent was not obtained from the resident or the surrogate decision-maker before the self-release belt was applied. The DON stated the resident ' s RP must be informed before applying the self-release belt to the resident to ensure the resident ' s rights are being respected.<br><br>During a concurrent observation and interview on 6/27/2024 at 4:02 p.m. with the DON, inside Resident 1's room, the DON asked Resident 1 if she can unbuckle the self-release belt. Resident 1 was observed attempting to unbuckle the self-release belt and stated, I can't. The DON stated since Resident 1 was unable to unbuckle the self-release belt, the self-release belt is considered a restraint.<br><br>A review of Posey Self-Releasing Padded Belt manufactures guidelines indicated, Caution this product is designed for self-release. If the patient is not able to easily self-release, it is considered a restraint and must be prescribed by a physician. The manufactures guidelines further indicates:<br><br>Before applying any restraint:<br><br>- Use restraint only when all other options have failed. Use the least restrictive device for the shortest time, until you find a less restive alternative. Patients have the right to be free from restraint.<br><br>- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.<br><br>- A restraint must only be used in accord with the patient ' s individualized Care plan.<br><br>A review of the facility ' s P&P titled, Physical Restraint, with no revision date, indicated a physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one ' s body.<br><br>5. The licensed nurse shall be responsible for obtaining an order from the attending physician, which is to include:<br><br>a. specific type of restraint.<br><br>b. purpose of the restraint.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | c. time and place of application.<br><br>d. approaches to prevent decreased function when applicable. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43878<br><br>Based on observation, interview, and record review the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the patient ' s body that he or she cannot easily remove that restricts freedom of movement or normal access to one ' s body) to one of three sampled residents (Resident 1) by failing to obtain an informed consent from Resident 1 ' s representative prior to application of a restraint (self-release seat belt).<br><br>This deficient practice had the potential to result in the restriction of residents ' freedom of movement, a decline in physical functioning, psychosocial harm, and physical harm.<br><br>A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 3/27/2024 and readmitted the resident on 6/7/2024 with diagnoses including muscle weakness, type 2 diabetes mellitus (DM- a disease that occurs when your blood glucose, also called blood sugar, is too high), and obsessive-compulsive behavior (a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts [obsessions], engages in repetitive behaviors [compulsions], or both). The Admission Record indicated the Primary Decision Maker was Responsible Party 1 (RP 1).<br><br>A review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/23/2024, indicated Resident 1 was moderately impaired (decision making poor, requires cues and supervision). The MDS indicated Resident 1 required moderate assistance with showering and requires touching assistance with oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and with personal hygiene.<br><br>A review of Resident 1's Care Plan, developed on 5/23/2024 indicated Resident 1 was at risk for fall and or injuries secondary to poor safety awareness and actual fall on 5/23/2024. The interventions included to bring the resident to activities, have CNA take the resident to the bathroom as indicated and before bringing to activities and if in wheelchair place at the table and lock wheelchair near activity department.<br><br>A review of Resident 1's Medication Administration Record (MAR- a report detailing the drugs administered to a patient by a healthcare professional at a treatment facility) dated 6/23/2024 for insulin regular human injection solution inject as per sliding scale, indicated Resident 1 ' s blood sugar was 315 and was given 8 units of insulin by Licensed Vocational Nurse 2 (LVN 2) on 6/23/2024.<br><br>A review of Resident 1's Fall Risk assessment dated [DATE] indicated Resident 1 had a fall risk score of 24 (a score of 18 or more is High Risk).<br><br>A review of Resident 1's Physician Orders dated 6/23/2024 at 5 p.m. indicated an order for self-release seat belt (SRSB) while in wheelchair for positioning. Informed consent obtained by medical doctor from RP after explanation of risk and benefits. Ensure equipment is in place and functioning properly.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident 1's Restraint-Physical dated 6/23/2024 at 5 p.m. indicated Resident 1 had unsteady gait, frequent falls and was agitated, and unable to be redirected. The summary indicated to use self-release belt while in wheelchair for proper positioning secondary to leaning forward. The date and time of first application indicated 6/23/2024 at 5 p.m., the doctor was notified on 6/23/2024 at 5 p.m. and Family Member 1 (FM 1) was notified on 6/23/2024 (no time indicated).<br><br>A review of Resident 1's Physician Orders dated 6/23/2024 at 8 p.m. indicated to discontinue use of self-release seat belt (SRSB) while in wheelchair for positioning. Informed consent obtained by medical doctor from RP after explanation of risk and benefits. Ensure equipment is in place and functioning properly, per RP request.<br><br>During an interview on 6/27/2024 at 11:42 a.m., with FM 1, FM 1 stated the Director of Nursing (DON) spoke to her recently (unsure of the date and time) and the DON stated that Resident 1 was improperly restrained and (the DON) wanted Resident 1 to use a lap buddy, to which RP 1 agreed to. FM 1 stated the facility did not obtain FM 1 and RP 1 ' s consent before using the self-release seat belt on Resident 1 on 6/23/2024. FM 1 stated she came into the facility on [DATE] and observed Resident 1 with a restraint.<br><br>During an interview on 6/27/2024 at 2 p.m. with the DON, the DON stated RP 1 had a concern regarding the use of self- release belt on 6/23/2024. The DON stated Registered Nurse 1 (RN 1) called the doctor on 6/23/2024 around 5 p.m. because Resident 1 was agitated, and staff was not able to redirect Resident 1. The DON stated Resident 1's family was not notified of Resident 1 using the self-release belt. The DON stated the self-release belt was applied on Resident 1 on 6/23/2024 at 5 p.m. and was discontinued on 6/23/2024 at 8 p.m. The DON stated the resident's family must be notified if there is an emergent situation that requires the use of a restraint.<br><br>During an interview on 6/27/2024 at 2:45 p.m. with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated on 6/23/204 around 4:30 p.m. LVN 2 checked Resident 1's blood sugar and it was low (cannot recall the level) and offered Resident 1 orange juice. LVN 2 stated Resident 1 was leaning forward, with an unsteady gait while the resident was sitting in the wheelchair, due to low blood sugar and the resident kept getting up to go to the bathroom without assistance. LVN 2 stated a CNA was assigned to Resident 1 to monitor and to remind the resident to not get up without assistance, but the CNA had to leave to assist other residents with their meals and that is when LVN 2 asked Registered Nurse 1 (RN 1) for an order for the self-release belt. LVN 2 stated the self-release belt was applied to Resident 1 around on 6/23/2024 at 5 p.m., but she did not call RP 1 or the resident ' s family for a consent. LVN 2 stated FM 1 came to facility around 6:30 p.m. and the self-release belt was taken off around 7:30 p.m. or 8 p.m. LVN 2 stated the resident ' s family should have been informed prior to application of the restraint so they can consent or refuse its use.<br><br>During an interview on 6/27/2024 at 3:26 p.m. with RN 1, RN 1 stated on 6/23/2024 at 5 p.m. LVN 2 told RN 1 that Resident 1 was agitated, kept going to the bathroom and was unable to be redirected. RN 1 stated, LVN 2 was afraid Resident 1 would fall so RN 1 stated she called the doctor and got an order to apply the self-release belt to Resident 1. RN 1 stated FM 1 came between 6:30 pm and 7 p.m. and stated to LVN 2 FM 1 did not want the on Resident 1. RN 1 stated she informed the doctor that FM 1 refused the use of the self-release belt, and the doctor discontinued the order. RN 1 stated the self-release belt was discontinued around 8 p.m. RN 1 stated she did not obtain consent from Resident 1's RP or family member prior to application of the self-release belt to Resident 1.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent record review and interview on 6/27/2024 at 3:50 p.m. with the DON, Resident 1 ' s Physician Orders dated 6/23/2024 at 5 p.m. and the facility policy Physical Restraint were reviewed. The DON stated the seat release belt was ordered by the doctor for positioning. The DON stated the informed consent was not obtained from the resident or the surrogate decision-maker before the self-release belt was applied. The DON stated the resident ' s RP must be informed before applying the self-release belt to the resident to ensure the resident ' s rights are being respected.<br><br>During a concurrent observation and interview on 6/27/2024 at 4:02 p.m. with the DON, inside Resident 1's room, the DON asked Resident 1 if she can unbuckle the self-release belt. Resident 1 was observed attempting to unbuckle the self-release belt and stated, I can't. The DON stated since Resident 1 was unable to unbuckle the self-release belt, the self-release belt is considered a restraint.<br><br>A review of Posey Self-Releasing Padded Belt manufactures guidelines indicated, Caution this product is designed for self-release. If the patient is not able to easily self-release, it is considered a restraint and must be prescribed by a physician. The manufactures guidelines further indicates:<br><br>Before applying any restraint:<br><br>- Use restraint only when all other options have failed. Use the least restrictive device for the shortest time, until you find a less restive alternative. Patients have the right to be free from restraint.<br><br>- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.<br><br>- A restraint must only be used in accord with the patient ' s individualized Care plan.<br><br>A review of the facility ' s P&P titled, Physical Restraint, with no revision date, indicated a physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one ' s body.<br><br>5. The licensed nurse shall be responsible for obtaining an order from the attending physician, which is to include:<br><br>a. specific type of restraint.<br><br>b. purpose of the restraint.<br><br>c. time and place of application.<br><br>d. approaches to prevent decreased function when applicable. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>43878<br><br>Based on interview and record review, the facility failed develop a comprehensive person-centered care plan for one of three sampled residents (Resident 1) for the use of self-release seat belt.<br><br>This deficient practice had the potential to negatively affect the resident's physical wellbeing and inhibit Resident 1's freedom of movement and activity.<br><br>Findings:<br><br>A review of Resident 1's Admission Record indicated the facility admitted the resident on 3/27/2024 and readmitted the resident on 6/7/2024 with the diagnoses that included muscle weakness, type 2 diabetes mellitus (DM- a disease that occurs when your blood glucose, also called blood sugar, is too high), and obsessive-compulsive behavior (a long-lasting disorder in which a person experiences uncontrollable and recurring thoughts [obsessions], engages in repetitive behaviors [compulsions], or both). The Admission Record indicated Primary Decision Maker was Responsible Party 1 (RP 1).<br><br>A review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/23/2024, indicated Resident 1 was moderately impaired (decision making poor, requires cues and supervision). The MDS indicated Resident 1 required moderate assistance with showering and requires touching assistance with oral hygiene, toileting, lower body dressing, putting on and taking off footwear, and with personal hygiene.<br><br>A review of Resident 1's Physician Orders dated 6/23/2024 at 5 p.m. indicated an order for self-release seat belt (SRSB) while in wheelchair for positioning. Informed consent obtained by medical doctor from RP after explanation of risk and benefits. Ensure equipment is in place and functioning properly.<br><br>A review of Resident 1's Restraint-Physical dated 6/23/2024 at 5 p.m. indicated Resident 1 had unsteady gait, frequent falls and was agitated, and unable to be redirected. The summary indicated to use self-release belt while in wheelchair for proper positioning secondary to leaning forward. The date and time of first application indicated 6/23/2024 at 5 p.m., the doctor was notified on 6/23/2024 at 5 p.m. and Family Member 1 (FM 1) was notified on 6/23/2024 (no time indicated).<br><br>During an interview on 6/27/2024 at 3:50 p.m. with the DON, the DON stated there was no care plan created for Resident 1's use of self-release belt. The DON stated there should be a care plan for the use of a restraint.<br><br>During a concurrent observation and interview on 6/27/2024 at 4:02 p.m. with the DON, inside Resident 1's room, DON asked Resident 1 if she can unbuckle the self-release belt. Resident 1 was observed attempting to unbuckle the self-release belt and stated, I can't. The DON stated since Resident 1 was unable to unbuckle the self-release belt, the self-release belt is considered a restraint.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555686 | A. Building<br>B. Wing | 06/27/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Studio City Rehabilitation Center | 11429 Ventura Blvd<br>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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Posey Self-Releasing Padded Belt manufactures guidelines indicated, Caution this product is designed for self-release. If the patient is not able to easily self-release, it is considered a restraint and must be prescribed by a physician. The manufactures guidelines further indicates:<br><br>Before applying any restraint:<br><br>- Use restraint only when all other options have failed. Use the least restrictive device for the shortest time, until you find a less restive alternative. Patients have the right to be free from restraint.<br><br>- Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and/or guardian to help ensure cooperation.<br><br>- A restraint must only be used in accord with the patient's individualized Care plan.<br><br>A review of the facility's P&P titled, Physical Restraint, with no revision date, indicated a physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body.<br><br>5. The licensed nurse shall be responsible for obtaining an order from the attending physician, which is to include:<br><br>a. specific type of restraint.<br><br>b. purpose of the restraint.<br><br>c. time and place of application.<br><br>d. approaches to prevent decreased function when applicable.<br><br>e. informed consent obtained from resident or from surrogate decision-maker.<br><br>10. The plan of care shall specify the reason for the use of the restraint, the type, when and where it is to be used.<br><br>A review of the facility's P&P titled, The Resident Care Plan , with no revision date, indicated to provide an individualized nursing care plan and to promote continuity of resident care. |