

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555686	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024
NAME OF PROVIDER OR SUPPLIER Studio City Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43497</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for one of three sampled residents (Resident 1) on 9/15/2024 when Resident 2 punched Resident 1 on the face.</p> <p>This deficient practice resulted in Resident 1 being subjected to physical abuse by Resident 2 while under the care of the facility. Resident 1 sustained swelling on the left side of his face and right side of his face, and purple discoloration (change in natural skin color) to the right eye and left eye. Based on the reasonable person concept (refers to a tool to assist the survey team's assessment of the severity level of negative, or potentially negative, psychosocial outcome the deficiency may have had on a reasonable person in the resident's position) due to Resident 1's severely impaired cognition (ability to think and make decisions), an individual subjected to physical abuse may have psychological (mental or emotional) effects including feelings of hopelessness (a feeling or state of despair or lack of hope), helplessness (the belief that there is nothing that anyone can do to improve a bad situation), and humiliation.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated the facility originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), metabolic encephalopathy (a brain dysfunction that occurs due to chemical imbalance), and Alzheimer's disease (a progressive disease that destroys memory and thinking skills).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool), dated 7/24/2024, indicated Resident 1 had severely impaired cognition and was dependent on staff with oral hygiene, toilet hygiene, bathing, dressing, and personal hygiene.</p> <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Change of Condition (COC - a significant change in a resident's health status), dated 9/15/2024, timed at 2:01 p.m., the COC indicated that on 9/15/2024 at 1:45 p.m., Resident 3 (Resident 1 and Resident 2's roommate) was lying down in his bed when Resident 1 came from outside the room. Resident 1 wheeled towards his (Resident 1's) bed to lie down. Resident 2, who was sitting on his (Resident 2's) bed, stood up and walked towards Resident 1's bed, grabbed Resident 1's call light, and hit Resident 1 in the face and went back to his (Resident 2's) bed. Resident 3 immediately went to the nursing station to ask for help. Upon Registered Nurse Supervisor's (RN Supervisor's) assessment, Resident 1 was noted with discoloration and swelling on the left and right eye requiring an ice pack to be placed on Resident 1's face.</p> <p>During a review of Resident 1's Medication Administration Record (MAR- a report detailing the medications administered to a resident), dated 9/15/2024 at 4:05 p.m., the MAR indicated Resident 1 received Tylenol (a medication used to treat pain) 650 mg (milligram- unit of measurement) by mouth for mild pain (pain rated at one to four on a pain scale from zero [0] to 10, where 10 is the worst possible pain) of 3 out of 10 pain level related to Resident 1's complaint of pain on his right eye and left eye. Further review of Resident 1's MAR, dated 9/16/2024 at 4:01 a.m., indicated Resident 1 received Tylenol 650 mg by mouth for a pain level of 3 out of 10.</p> <p>During a concurrent observation and interview on 9/17/2024 at 1:00 p.m., with Resident 1, Resident 1 was observed with swelling on the left side and right side of his face and purple discoloration to the right eye and left eye. Resident 1 stated that his eyes hurt when he closes and opens them. Resident 1 was unable to recall much of the incident with Resident 2 but remembers someone standing over him and punching him in the face.</p> <p>During a review of Resident 3's Admission Record, the Admission Record indicated the facility originally admitted Resident 3 on 1/24/2020 and readmitted on [DATE] with diagnoses including type two diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel.), chronic pulmonary embolism (blockage of the pulmonary arteries), and a history of falling.</p> <p>During a concurrent observation and interview 3 on 9/17/2024 at 1:30 p.m. with Resident, Resident 3 was in bed awake, alert, and verbally responsive. Resident 3, while demonstrating with his two (right and left) closed fists up in the air using forward and backward motion, stated he saw Resident 2 punching Resident 1 with closed fists at Resident 1's face. Resident 3 stated no words were exchanged prior to the incident, but he (Resident 3) just saw Resident 2 punching Resident 1's face. Resident 3 stated he then went to the nurse's station to tell the charge nurse immediately.</p> <p>During a review of Resident 2's Admission Record, the Admission Record indicated the facility originally admitted Resident 2 on 12/30/2021 and readmitted on [DATE] with diagnoses that included dementia, bipolar disorder (a serious mental illness that causes unusual shifts in mood), and schizoaffective disorder (a mental illness that can affect your thoughts, mood, and behavior).</p> <p>During a review of Resident 2'S MDS, dated [DATE], indicated Resident 2 had severely impaired cognition and required supervision with eating, oral hygiene, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's current Plan of Care, dated 1/3/2023, the Plan of Care indicated Resident 2 had altered behavior patterns manifested by episodes of outbursts of anger, and episodes of inability to cope with stimuli (anything that can trigger a physical or behavioral change) leading to episodes of anger. The interventions included to assess what may cause the behavior, what may trigger the behavior and attempt to reduce and eliminate those triggers if possible. The Plan of Care further indicated that on 9/15/2024 Resident 2 had an episode of being physically aggressive towards Resident 1.</p> <p>During an interview on 9/17/2024 at 2:00 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 3 came to the nurse's station to notify her (cannot recall the time) that he (Resident 3) witnessed Resident 2 punching Resident 1 in the face with closed fists. LVN 1 stated Resident 1 was noted with swelling and redness to the right side of the face including the eyes. LVN 1 stated she asked Resident 1 what happened, and Resident 1 told her that he (Resident 1) was punched in the face. LVN 1 asked Resident 2 why he punched Resident 1 in the face, but she (LVN 1) stated he (Resident 2) had no response.</p> <p>During a concurrent interview and record review on 9/17/2024 at 3:00 p.m., with RN Supervisor, Resident 1's COC form, Physician's Order and MAR were reviewed. RN Supervisor stated she was notified (cannot recall the time) by LVN 1 that Resident 2 punched Resident 1 in the face, and she (RN Supervisor) went immediately to assess both residents (Residents 1 and 2). RN Supervisor stated, that when she went inside the room, she noted Resident 1 with a swollen face with redness to the right eye. RN Supervisor stated she asked Resident 2 what happened, and he stated he was provoked, but did not disclose further information. RN Supervisor requested for LVN 1 to apply ice to Resident 1's face and administer Tylenol for pain. RN Supervisor further stated the local law enforcement were notified and Resident 2 was transferred to the hospital for further behavioral evaluation.</p> <p>During an interview on 9/19/2024 at 11:00 a.m., with the Director of Nurses (DON), the DON stated, the incident was unpredictable, but she provided training to the staff regarding prevention of abuse and communication between LVNs and Certified Nurse Assistants. The DON stated that daily huddles should be conducted to notify of any resident experiencing any significant behavioral issues.</p> <p>During a review of the current facility-provided policy and procedure titled, Monitoring Residents undated, indicated those residents identified to have behavioral symptoms potential for conflict and anger shall be monitored in accordance with plan of care developed to address such problems. Monitoring of such residents shall be the responsibility of, but not limited to, direct caregivers, charge nurses, nursing supervisors, and members of the interdisciplinary team.</p> <p>During a review of the current facility-provided policy and procedure titled, Abuse & Mistreatment of Residents, undated, indicated to uphold a resident's right to be free from verbal, sexual, and mental abuse, corporal punishment, involuntary seclusion, and exploitation. Abuse is defined as the willful infliction of injury, unreasonable confinement, or punishment with resulting physical hard or pain or mental anguish, deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Residents identified to have behavioral symptoms with a potential for conflict and anger shall be monitored in accordance with plans of care developed to address such problems. Monitoring of such residents shall be the responsibility of, but not limited to, direct caregivers, Charge Nurses, Nursing Supervisors, and members of the interdisciplinary team.</p>		