

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 02/13/2025
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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to ensure the Attending Physician (AP) was notified timely for one of four sampled residents (Resident 1).</p> <p>This deficient practice resulted in a delay of obtaining appropriate instructions from the physician for proper management.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 2/1/2025, with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract), age related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) with current pathological vertebra fracture (broken bone caused by disease) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities).</p> <p>During a record review of Resident 1's Change of Condition (COC), dated 2/1/2025, timed at 10:20 p.m., the COC indicated Resident 1 was found sitting on the floor mat. The COC indicated on 2/1/2025, at 10:20 p.m., Certified Nursing Assistant 1 (CNA 1) notified Licensed Vocational Nurse 1 (LVN 1) that Resident 1 was sitting on the floor mat. The COC indicated the AP was notified on 2/1/2025, at 10:20 p.m., and the AP ordered a stat (immediately) left leg X-ray (a diagnostic imaging test to create pictures of the inside of the body).</p> <p>During a record review of Resident 1's Physician Order, dated 2/1/2025, the Physician order indicated an order for stat left leg X-ray.</p> <p>During a record review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.</p> <p>During a record review of Resident 1's Interdisciplinary Team (IDT-a coordinated group of experts from several different fields who work together) Fall Risk, dated 2/5/2025, the IDT indicated on 2/2/2025 at 6 a.m., LVN 2 notified AP that stat X-ray was not done.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/13/2025, at 9:53 a.m., with Registered Nurse 1 (RN 1), Resident 1's COC, dated 2/1/2025, was reviewed. RN 1 stated if AP ordered stat X-ray and was not done within two hours, staff should have called to notify the AP. RN 1 stated the importance of notifying the AP within two hours was to get further orders as soon as possible.</p> <p>During an interview on 2/13/2025, at 10:10 a.m., with the Director of Nursing (DON), the DON stated if stat X-ray was ordered and not done within four to six hours, nurses should have notified the AP. The DON stated LVN 2 called AP on 2/2/2025 at 6 a.m. and it was a late notification.</p> <p>During a record review of facility's policy and procedure (PnP) titled, Change of Condition, dated 1/24/2017, and last reviewed on 4/17/2024, the PnP indicated, Upon a change in condition for any reason, nursing staff members are to take the following actions. Physician shall be called promptly.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>42311</p> <p>Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of four sampled residents (Resident 1).</p> <p>This deficient practices had the potential to cause confusion in care and the medical records containing inaccurate documentation.</p> <p>Findings:</p> <p>During a record review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 2/1/2025, with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract), age related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) with current pathological vertebra fracture (broken bone caused by disease) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities).</p> <p>During a record review of Resident 1's Change of Condition (COC), dated 2/1/2025, timed at 10:20 p.m., the COC indicated Resident 1 was found sitting on the floor mat. The COC indicated Responsible Party (RP) was notified on 2/1/2025 at 12:00 a.m.</p> <p>During a record review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.</p> <p>During a concurrent interview and record review on 2/13/2025, at 9:53 a.m. with Registered Nurse 1 (RN 1), Resident 1's COC, dated 2/1/2025 was reviewed. RN 1 stated Resident 1's COC for RP notification was documented wrong. RN 1 stated COC should indicate RP was notified on 2/2/2025 at 12 a.m. RN 1 stated the importance of complete and accurate records was to show that intervention was done timely to keep Resident 1 safe.</p> <p>During a concurrent interview and record review on 2/13/2025, at 10:10 a.m. with the Director of Nursing (DON), Resident 1's COC dated 2/1/2025 and Resident 1's Progress Notes dated 2/1/2025 and 2/2/2025 were reviewed. The DON stated time RP was called was not documented in COC and Progress Note. The DON stated the importance of documenting accurately was to prove that RP was notified right away.</p> <p>During a concurrent interview and record review on 2/13/2025 at 10:28 a.m., with the DON, facility's policy and procedure (PnP) titled, Charting and Documentation, dated 7/2017 and last reviewed on 4/17/2024, the PnP indicated All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT- a coordinated group of experts from several different fields who work together) regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative) complete and accurate. The DON stated the facility's PnP indicated to document accurately.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/13/2025 at 1:31 p.m., with RN 2, RN 2 stated she (RN 2) called RP on 2/1/2025 between 11 p.m. to 2/2/2025 at 12 a.m., RN 2 admitted she documented the wrong date.</p>