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	04/04/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 42311 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2), who was on a self-release belt restraint (a device, often used in healthcare settings, designed to secure a patient to a bed or chair while still allowing them to move or sit up), was free from unnecessary physical restraint (a strap or other thing that holds a person in place) when on 4/2/2025 at 8:56 a.m., Resident 2's lap was observed covered with a white blanket covering his lower abdomen to his knees with edges wrapped around to his (Resident 2) sides and secured to Resident 2's wheelchair. Findings: During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 2/13/2025, with diagnoses that included metabolic encephalopathy (change in how your brain works due to an underlying condition), acute respiratory failure (when the lungs cannot release enough oxygen into your blood) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities). During a review of Resident 2 ' s History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 2/13/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's physician order, dated 2/13/2025 at 6 p.m., the physican order indicated for Resident 2 to be on a self-release seat belt while in wheelchair. The physician order indicated there was consent (the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention) obtained by the physician. During a review of Resident 2 ' s Minimum Data Set (MDS - a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 2 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent from staff for all activities of daily living (ADL - activities such as bathing, dressing and toileting a person performs daily). (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/2/2025, at 8:56 a.m., inside Resident 2 ' s room, observed Resident 2 seated on a wheelchair with a white blanket covering his (Resident 2) lap, covering his lower abdomen to his knees with edges wrapped around to his (Resident 2) sides and secured to Resident 2's wheelchair. Observed Resident 2 also had a self-release belt. During an interview on 4/2/2025, at 9:45 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 2 had a self-release belt that he can remove but the white blanket tied at the back of the wheelchair was not a self- release. LVN 1 stated Resident 2 should not have that white blanket tied on his (Resident 2) back. LVN 1 stated staff should not tie it at the back of Resident 2. During an interview on 4/2/2025, at 10:22 a.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she (CNA 1) was the assigned CNA for Resident 2, and when she (CNA 1) came in the morning, Resident 2 was already seated on the wheelchair, but she (CNA 1) did not notice that he (Resident 2) was tied. CNA 1 stated it was another CNA (CNA 2) who fed Resident 2 at breakfast. During an interview on 4/2/2025, at 10:45 a.m., with CNA 2, CNA 2 stated she (CNA 2) had fed Resident 2 today 4/2/2025 at 7:30 a.m. and Resident 2 was already seated in the wheelchair. CNA 2 stated she (CNA 2) did not notice that Resident 2 was tied at the back. CNA 2 stated Resident 2 cannot reach out on his back to tie himself in the wheelchair. CNA 2 stated she (CNA 2) should have checked Resident 2 to make sure residents are not on unnecessary restraints. CNA 2 stated Resident 2 had a self-release belt to prevent fall. CNA 2 stated if Resident 2 was tied that means he (Resident 2) was on restraint. CNA 2 stated Resident 2 will have limited movement due to the restraint. During an interview on 4/2/2025, at 10:57 a.m., with the Assistant Director of Nursing (ADON), the ADON stated LVN 1 notified him (ADON) that Resident 2 was tied up in the wheelchair. The ADON stated he (ADON) went to Resident 2 ' s room and saw the restraint. The ADON stated he (ADON) noted the blanket around Resident 2 tied on the back of the wheelchair. The ADON stated he (ADON) untangled and removed the tied blanket. The ADON stated if resident are tied it is considered a restraint. The ADON stated they do not have a physician order to use blanket as a restraint. The ADON stated if no physician order for use of restraint, it is a violation of resident's right to be free of restraint. The ADON stated the use of blanket as a restraint can cause entrapment and injury to Resident 2. The ADON stated the use of a restraint needs a physician order and residents need to be monitored and both (physician order and monitoring) were not done. During an interview on 4/2/2025, at 11:19 a.m., with the Director of Nursing (DON), the DON stated Resident 2 had an order for self-release belt but not for the use of a blanket tied at the back of Resident 2. The DON stated it was wrong to apply blanket as a restraint and the facility does not have an excuse for it. The DON stated the nurses failed to use restraint only with physician order and failed to check Resident 2 was on restraint. The DON stated residents should be restraint free. The DON stated their policy for physical restraint was not followed. The DON stated the facility have a process of starting a restraint by assessing the resident, obtaining a physician order, and monitoring the resident. The DON stated they (facility staff) cannot just tie Resident 2. During a review of facility ' s policy and procedure (P&P) titled, Physical Restraint, undated and last reviewed on 4/17/2024, the P&P indicated, Physical Restraint are 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. Physical restraint assessment and use shall be managed accordingly: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. If other interventions such as lowering bed, using pillows, alarms, wedge cushions, did not work, a physical restraint assessment shall be completed by the licensed nurse with input from the interdisciplinary team (IDT-a coordinated group of experts from several different fields who work together). 5. The licensed nurse shall be responsible for obtaining an order from the attending which is to include: a. Specific type of restraint. b. Purpose of the restraint. c. Time and place of application. d. Approaches to prevent decreased functioning when applicable. e. Informed consent obtained from resident or from surrogate decision maker. 13. Staff members are to be in-service on proper application of restraints. A restraint shall be applied in such a manner that speedy removal is possible in the event of a fire or other emergency.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to develop a comprehensive care plan for three of three sampled residents (Residents 1, 2, and 3) by failing to ensure a care plan was develop on residents ' potential exposure to scabies (a skin condition caused by tiny mites that burrow [a hole or tunnel] under the skin, leading to intense itching and a rash which is contagious [disease that they can pass to other people] and can spread through prolonged skin-to-skin contact). This deficient practice had the potential for delayed provision of necessary care and services and spread of scabies among residents. Findings: a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/3/2019, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic pain syndrome (ongoing pain that persists beyond the expected healing time or occurs with a chronic health condition, lasting for months or years and significantly impacting daily life) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/18/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/1/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for toileting, showering, dressing and personal hygiene. The MDS indicated Resident 1 was always continent (able to control) of bowel and bladder functions. During a review of Resident 1 ' s Physician Order, dated 2/18/2025, the Physician Order indicated Elimite (medication used to treat scabies) 5 percent (%- per one hundred) cream, apply from neck to toes, leave on for 12 hours, then wash off one time only for asymptomatic (no symptoms) prophylaxis (an attempt to prevent disease)related to probable exposure to scabies for one day. During a review of Resident 1 ' s Treatment Administration Record (TAR-daily documentation record used by a licensed nurse to document treatments given to a resident), dated 2/2025, the TAR indicated on 2/20/2025, at 9:18 p.m., Licensed Vocational Nurse 4 (LVN 4) applied Elimite 5% cream to Resident 1 from neck to toes related to probable exposure to scabies. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 11/2/2022, with diagnoses that included metabolic encephalopathy (brain dysfunction caused by imbalances in the body's metabolism or underlying medical conditions, leading to changes in mental status), generalized muscle weakness and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities). During a review of Resident 2 ' s H&P, dated 2/13/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent to staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2 ' s Physician Order, dated 2/18/2025, the Physician Order indicated Elimite 5% cream, apply from neck to toes, leave on for 12 hours, and then wash off one time only for asymptomatic prophylaxis treatment related to probable exposure to scabies for one day. During a review of Resident 2 ' s TAR, dated 2/2025, the TAR indicated on 2/20/2025, at 9:18 p.m., LVN 4 applied Elimite 5% cream to Resident 2 from neck to toes related to probable exposure to scabies. c. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted Resident 3 on 11/14/2023, with diagnoses that included atherosclerosis heart disease, (when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body become thick and stiff) unspecified chest pain and cardiomegaly (yourheart is larger than it should be). During a review of Resident 3 ' s H&P, dated 7/24/2024, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 3 needed moderate assistance from staff for toileting and showering. During a review of Resident 3 ' s Physician Order, dated 2/18/2025, the Physician Order indicated Elimite 5% cream, apply from neck to toes, leave on for 12 hours, and then wash off one time only for asymptomatic prophylaxis treatment related to probable exposure to scabies for one day. During a review of Resident 3 ' s TAR, dated 2/2025, the TAR indicated on 2/20/2025 at 9:18 p.m., LVN 4 applied Elimite 5% cream to Resident 3 from neck to toes related to probable exposure to scabies. During a concurrent interview and record review on 4/3/2025, with the Director of Nursing (DON), Resident 1, 2, and 3 ' s Care Plans were reviewed. The DON stated there were no care plans developed for Residents 1, 2, and 3 ' s possible exposure to scabies. The DON stated the nurses should have developed care plans for treatment and monitoring of scabies. The DON stated nurses might not follow plan of care for scabies treatment and prevention causing possible spread of scabies. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility ' s policy and procedure (P&P) titled, The Resident Care Plan, undated and last reviewed on 4/17/2024, the P&P indicated, To provide an individualized nursing care plan and to promote continuity of resident care. An initial care plan to provide immediate needs will be developed timely. 2. Record the following: 1. Procedures directly ordered by the physician. 2. Procedures associated with specific resident teaching. 3. Care necessitated by the resident s individual needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 42311 Based on observation, interview, and record review, the facility failed to ensure the resident received care consistent with professional standards of practice to prevent pressure ulcer (a localized injury to the skin and or underlying tissue usually over a bone prominence as a result of pressure or pressure in combination with shear [occur between the internal body structures and skin tissues typically moving in opposite directions and may lead to deep tissue injury]) for one of three sampled residents (Resident 5) by failing to ensure no excessive padding was placed over the low air loss mattress (LALM-a mattress designed to distribute the patient's body weight over a broad surface area to prevent skin breakdown and treat pressure ulcers) as indicated in the manufacturer ' s manual and facility ' s policy. This deficient practice had the potential for the development and worsening of pressure ulcers or injuries for Resident 5. Findings: During a review of Resident 5 ' s Admission Record, the Admission Record indicated the facility admitted Resident 5 on 1/22/2021, with diagnoses that included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified (unconfirmed) heart failure (the heart can't pump enough blood to meet the body's needs, often due to weakened or stiff heart muscle, and can lead to symptoms like shortness of breath and fatigue), and paroxysmal atrial fibrillation (a fast, irregular heartbeat that only lasts a few hours or days). During a review of Resident 5 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 10/11/2024, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 5 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 5 was dependent to staff for toileting, showering and personal hygiene. The MDS indicated Resident 5 was always incontinent (unable to control) of bowel and bladder functions. The MDS indicate Resident 5 was at risk for developing pressure ulcers and injuries. During a review of Resident 5 ' s Physician Order, dated 2/6/2025, the Physician Order indicated LALM for wound care and management. During a concurrent observation and interview on 4/4/2025, at 8:34 a.m., with Certified Nursing Assistant 3 (CNA 3), at Resident 5 ' s bedside. Observed Resident 5 on LALM with multiple layers of linen. CNA 3 counted each layer. CNA 3 stated there were one bed sheet, one linen folded into four, two washable chux, and Resident 5 was on incontinent brief. CNA 3 stated there were a total of eight layers between Resident 5 and Resident 5 ' s LALM. CNA 3 stated there should only be one linen and one incontinence brief (a disposable, absorbent garment designed to absorb urine and/or feces). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2025, at 8:36 a.m. with Registered Nurse 1 (RN 1), RN 1 stated Resident 5 on LALM needed four layers of linen in between the resident (Resident 5) and LALM. RN 1 stated Resident 5 needed bed sheet, chux, linen, and incontinence brief. During an interview on 4/4/2025, at 8:25 a.m., with the Infection Preventionist (IP) who was covering for the Director of Staff Development (DSD), the IP stated there should only be two layers including incontinence brief between Resident 5 and LALM. The IP stated RN 1 should know as she (RN 1) was already inserviced (educated). The IP stated multiple layers of linen in between can put Resident 5 at risk for pressure ulcer. During an interview on 4/4/2025 at 11:14 a.m., with the Director of Nursing (DON), the DON stated the facility ' s standard was only two layers between a resident and LALM. The DON stated multiple layers can cause skin breakdown. The DON stated the LALM Operation Manual indicated no excessive layers. During a review of facility ' s Operation Manual for LALM, undated and last reviewed on 4/17/2024, the Operation Manual indicated, The LALM system is designed for prevention, treatment and management of pressure ulcers. Secure sheets loosely enough to ensure they do not interfere with cell alternation. When the mattress had been adjusted to a desired level of firmness, the patient can then lie on the mattress. During a review of facility ' s P&P titled, Care and Prevention of Pressure Sores, undated and last reviewed on 4/17/2024, the P&P indicated, The Charge Nurse and Treatment Nurse are to be responsible for determining which resident requires special supports, mattresses, foam padding. foot boarding or other preventative measures and for instructing the assigned nurse assistant in their use. Nursing and Care Duties: Making beds properly (example given, no wrinkles in linen, no excessive padding for incontinent residents).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for two of four sampled residents (Resident 1 and 2) by: 1. Failing to ensure Resident 1 ' s physician order was followed for oxycodone (medication used to treat pain) for severe pain level between seven to ten. 2. Failing to ensure Resident 2 ' s physician order was followed to hold diltiazem (medication used to treat high blood pressure) for systolic blood pressure (sbp - the top number in a blood pressure reading, indicating the pressure in your arteries when your heart beats) below 110. This failure had the potential to result in medication error and can cause hypotension (low blood pressure). Findings: a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/3/2019, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified (unconfirmed) low back pain, and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/18/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool) dated 1/1/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for toileting, showering, dressing and personal hygiene. The MDS indicated Resident 1 was always continent (able to control) of bowel and bladder functions. During a review of Resident 1 ' s Physician Order dated 11/26/2022, the Physician Order indicated oxycodone hydrochloride tablet 30 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give 30 mg by mouth every six hours as needed for severe pain level of seven to ten. During a review of Resident 1 ' s Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/2025, the MAR indicated Licensed Vocational Nurse 6 (LVN 6) and LVN 7 had administered oxycodone 30 mg to Resident 1 with a pain level six on the following dates: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. 3/1/2025 at 10 a.m. b. 3/7/2025 at 10 p.m. c. 3/8/2025 at 4 p.m. d. 3/8/2025 at 10 p.m. e. 3/14/2025 at 10 p.m. f. 3/15/2025 at 10 p.m. g. 3/21/2025 at 10 p.m. h. 3/28/2025 at 10 p.m. i. 3/29/2025 at 10 p.m. During a concurrent interview and record review on 4/3/2025, at 12:30 p.m., with the Director of Nursing (DON), Resident 1 ' s Physician Order dated 11/26/2022, and MAR dated 3/2025, were reviewed. The DON stated LVN 6 and LVN 7 should have provided the correct pain medication according to Resident 1 ' s pain level. The DON stated LVN 6 and LVN 7 should perform a proper pain assessment, call the physician to adjust the physician order. The DON stated with pain level of six, acetaminophen (medication used to treat pain and fever) should have been administered. The DON stated the licensed nurses did not follow Resident 1's physician order. The DON stated oxycodone is habit forming (addictive) medication and can cause Resident 1 to ask for oxycodone even when he (Resident 1) did not have severe pain. b. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 11/2/2022, with diagnoses that included metabolic encephalopathy (brain dysfunction caused by imbalances in the body's metabolism or underlying medical conditions, leading to changes in mental status), other secondary hypertension (specific type of high blood pressure that has a known underlying cause) and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities). During a review of Resident 2 ' s H&P, dated 2/13/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent to staff for all activities of daily living (ADL-activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2 ' s Physician Order dated, 2/13/2025, the Physician Order indicated diltiazem hydrochloride (medication used to treat hypertension) oral tablet 60 mg, give one tablet by mouth every six hours for high blood pressure, hold for systolic blood pressure below 110. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s MAR dated 3/2025, the MAR indicated on 3/31/205, LVN 5 administered diltiazem to Resident 2 with a blood pressure of 108/70 millimeters of mercury (mmHg- a unit of measurement for pressure). During a concurrent interview and record review on 4/3/2025, at 12:30 p.m., with the DON, Resident 2 ' s Physician Order dated 2/13/2025, and MAR dated 3/2025, were reviewed. The DON stated Resident 2 ' s blood pressure on 3/31/2025, at 12 noon was 108/70 mmHg and physician order was to hold (stop) the diltiazem for sbp below 110. The DON stated LVN 5 should have held the medication to prevent further decrease in blood pressure. During a concurrent interview and record review on 4/4/2025 at 11:14 a.m., with the DON, facility ' s policy and procedure (P&P) tilted, Med Pass, undated and last reviewed on 4/17/2024, the P&P indicated A. Basic procedure: Prepare the medication correctly, administer the medication correctly, and chart the medication pass correctly. Make sure that during the course of a medication pass. The 5 Rights: Make sure that medications are administered according to: a. Right resident b. Right medications c. Right dose d. Right route/method e. Right time B. Do not administer medications according to memory. Never administer medications just because they are available, just because the family or resident requests, or just because certain meds are normally given in that dose at that time. C. Vital Signs When vital signs are included in med order, vital signs are to be taken just before medication is administered and by the med nurse. A vital sign taken by a Certified Nursing Assistant (CNA) at the beginning of a shift shall not be valid. The DON stated the facility ' s policy was to follow the physician's order.

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Studio City Rehabilitation Center	11429 Ventura Blvd Studio City, CA 91604

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to ensure three of four sampled residents (Residents 1, 2, and 3) who had no scabies (a parasitic infestation caused by tiny mites that burrow into the skin and lay eggs, causing intense itching and a rash) was not given Elimite (medication used to treat scabies) cream. This failure had the potential to result in Residents 1, 2, and 3 to receive unnecessary medications. Findings: a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/3/2019, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic pain syndrome (ongoing pain that persists beyond the expected healing time or occurs with a chronic health condition, lasting for months or years and significantly impacting daily life), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/18/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/1/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for toileting, showering, dressing and personal hygiene. The MDS indicated Resident 1 was always continent (able to control) of bowel and bladder functions. During a review of Resident 1 ' s Physician Order, dated 2/18/2025, the Physician Order indicated Elimite 5 percent (%- per one hundred) cream, apply from neck to toes, leave on for 12 hours, and then wash off one time only for asymptomatic (no symptoms) prophylaxis (an attempt to prevent disease) related to probable exposure to scabies for one day. During a review of Resident 1 ' s Treatment Administration Record (TAR-daily documentation record used by a licensed nurse to document treatments given to a resident), dated 2/2025, the TAR indicated on 2/20/2025, at 9:18 p.m., Licensed Vocational Nurse 4 (LVN 4) applied Elimite cream to Resident 1 from neck to toes related to probable exposure to scabies. During an interview on 4/2/2025, at 8:46 a.m., with Resident 1, Resident 1 stated he (Resident 1) received Elimite cream for scabies, but he (Resident 1) was not tested for scabies. Resident 1 stated he (Resident 1) got confused if he (Resident 1) had the scabies or not. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/2025, at 10:06 a.m., with the Treatment Nurse 1 (TN 1), TN 1 stated Resident 1 had no diagnosis of scabies but received Elimite cream on 2/18/2025, as prophylaxis for possible exposure to scabies. b. During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 11/2/2022, with diagnoses that included metabolic encephalopathy (brain dysfunction caused by imbalances in the body's metabolism or underlying medical conditions, leading to changes in mental status), generalized muscle weakness and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities). During a review of Resident 2 ' s H&P dated 2/13/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent to staff for all activities of daily living (ADL-personal hygiene, bed mobility, dressing, and transfers). During a review of Resident 2 ' s Physician Order dated 2/18/2025, the Physician Order indicated Elimite five % cream, apply from neck to toes, leave on for 12 hours, then wash off one time only for asymptomatic prophylaxis treatment related to probable exposure to scabies for one day. During a review of Resident 2 ' s TAR dated 2/2025, the TAR indicated on 2/20/2025, at 9:18 p.m., LVN 4 applied Elimite cream to Resident 2 from neck to toes related to probable exposure to scabies. During an interview on 4/2/2025, at 9:45 a.m., with LVN 1, LVN 1 stated Resident 2 had no diagnosis of scabies. c. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted Resident 3 on 11/14/2023, with diagnoses that included atherosclerosis heart disease, (when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body become thick and stiff) unspecified chest pain and cardiomegaly (your heart is larger than it should be). During a review of Resident 3 ' s H&P, dated 7/24/2024, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 3 needed moderate assistance from staff for toileting and showering. During a review of Resident 3 ' s Physician Order, dated 2/18/2025, the Physician Order indicated Elimite 5% cream, apply from neck to toes, leave on for 12 hours, and then wash off one time only for asymptomatic prophylaxis treatment related to probable exposure to scabies for one day. During a review of Resident 3 ' s TAR, dated 2/2025, the TAR indicated on 2/20/2025 at 9:18 p.m., LVN 4 applied Elimite cream to Resident 3 from neck to toes related to probable exposure to scabies. During an interview on 4/2/2025, at 9:45 a.m., with LVN 1, LVN 1 stated Resident 3 had scabies treatment but no diagnosis of scabies. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/2/2025, at 10:06 a.m., with TN 1, TN 1 stated no cases of scabies in the facility. During an interview on 4/2/2025, at 10:29 a.m., with the Infection Preventionist (IP), the IP stated Resident 4 was transferred out to the General Acute Care Hospital (GACH) on 2/13/2025, and his (Resident 4) roommates that time were Resident 1 and Resident 3. The IP stated Resident 4 was readmitted from the GACH with positive for scabies on 2/17/2025. The IP stated he (IP) and the TNs gave Elimite to the residents (Residents 1, 2, and 3) in Station B as prophylaxis. The IP stated Resident 1 and Resident 3 were not tested for the presence of scabies. During an interview on 4/2/2025, at 11:19 p.m., with the Director of Nursing (DON), the DON stated the facility ' s policy for scraping (this involves using a tool, often a scalpel or blade, to gently scrape the skin surface) resident was if the facility suspected cases of scabies. The DON stated there were no new suspected cases during the residents (Residents 1, 2, and 3) skin checks. The DON stated because there was one positive case of scabies in the facility reason that was why she (DON) did prophylaxis administration of Elimite. The DON stated it was an unnecessary medication administration because we were not on scabies outbreak. The DON stated scabies outbreak means two confirmed cases of scabies. During a concurrent interview and record review on 4/4/2025, at 11:14 a.m., with the DON, facility ' s policy and procedure (P&P) titled, Consultant Pharmacist services Provider Requirements, dated 10/2017, and last reviewed on 4/17/2025, the P&P indicated, A resident ' s drug regimen must be free of unnecessary drugs. An unnecessary drug is any drug when used in: i. Excessive dose (including a duplicate drug) ii. Excessive duration iii. Without adequate monitoring iv. Without adequate indication for its use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview and record review, the facility failed to implement infection control measures for three of four sampled residents (Resident 1, 2, and 3) by. 1. Failing to ensure Resident 1 was placed on contact isolation after physician ordered skin scraping (a medical procedure where a sample of skin cells is collected by gently scraping the surface of the skin with a sterile blade) to test for presence of scabies (a contagious skin condition caused by microscopic [so small as to visible only with microscope] mites [tiny bugs] burrowing [made a hole] into the skin). 2. Failed to ensure skin monitoring was done and documented in Residents 1, 2, and 3 ' s medical records after physician ordered the monitoring on 2/18/2025. These failures had the potential for the spread of scabies among residents and staff. Findings: a. During a review of Resident 1 ' s Admission Record, the Admission Record indicated the facility admitted Resident 1 on 12/3/2019, with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), chronic pain syndrome (ongoing pain that persists beyond the expected healing time or occurs with a chronic health condition, lasting for months or years and significantly impacting daily life) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 1 ' s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/18/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 1/1/2025, the MDS indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required supervision from staff for toileting, showering, dressing and personal hygiene. The MDS indicated Resident 1 was always continent (able to control) of bowel and bladder functions. During a review of Resident 1 ' s Physician Order, dated 4/3/2025, the Physician Order indicated skin scraping to rule out scabies. During an observation on 4/4/2025, at 8:23 a.m., at Resident 1 ' s door. Observed there was no contact isolation (are measures taken in healthcare settings to prevent the spread of germs through direct or indirect contact with a resident or their environment including the use of personal protective equipment [PPE-wearable equipment that is intended to protect healthcare personnel and the public from exposure to or contact with infectious agents] like gowns and gloves, using dedicated equipment, and careful hand hygiene) signage posted on the door and no PPE noted by Resident 1 ' s door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/2025, at 9:02 a.m. with Treatment Nurse 2 (TN 2), TN 2 stated Resident 1 ' s skin was scraped yesterday (4/3/2025 which was after the surveyor's visit) to rule out scabies. During an interview on 4/4/2025, at 9:35 a.m., with the Infection Preventionist (IP), the IP stated the physician saw Resident 1 on 4/2/2025 (during the surveyor's visit) and ordered skin scraping to rule out scabies and he (IP) tested and obtained the specimen from Resident 1 ' s left arm. The IP stated since the order was to rule out scabies, Resident 1 should have been on contact isolation. The IP stated contact isolation should have been started on 4/3/2025. The IP stated scabies can spread if Resident 1 was not placed on contact isolation. During an interview on 4/4/2025, at 11:14 a.m., with the Director of Nursing (DON), the DON stated Resident 1 should have been on contact isolation when the physician ordered the skin scraping to rule out scabies to prevent the spread of scabies. During a review of facility ' s policy and procedure (P&P) titled, Outbreak of Communicable Diseases, dated 4/2023 and last reviewed on 4/17/2024, the P&P indicated, The Infection Preventionist and the Director of Nursing are responsible for: a. Managing surveillance data. b. Monitoring ill residents and staff, c. Initiating transmission-based precautions (extra steps taken in healthcare settings to prevent the spread of infections from one person to another, especially when standard precautions like handwashing might not be enough), as appropriate. During a review of facility ' s P&P titled, Isolation-Categories of Transmission-Based Precautions, dated 4/2023, and last reviewed on 4/17/2024, the P&P indicated, When a resident is placed on transmission-based precautions. appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors aware of the need for and the type of precaution. The signage informs the staff of the type of precaution(s), instructions for use of PPE and or instructions to see a nurse before entering the room. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. b. During a review of Resident 1 ' s Physician Order, dated 2/18/2025, the Physician Order indicated monitor skin of generalized body for rashes (changes in the skin's appearance or texture, often characterized by redness, bumps, itching, or swelling), papules (a raised area of skin tissue), and itching. During a review of Resident 1 ' s Treatment Administration Record (TAR-a daily documentation record used by a licensed nurse to document treatments given to a resident), dated 2/2025, the TAR indicated Resident 1 ' s skin monitoring was started on 2/20/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s Admission Record, the Admission Record indicated the facility admitted Resident 2 on 11/2/2022, with diagnoses that included metabolic encephalopathy (brain dysfunction caused by imbalances in the body's metabolism or underlying medical conditions, leading to changes in mental status), generalized muscle weakness and unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities). During a review of Resident 2 ' s H&P, dated 2/13/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 was dependent to staff for all activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 2 ' s Physician Order, dated 2/18/2025, the Physician Order indicated monitor skin of generalized body for rashes, papules and itching. During a review of Resident 2 ' s TAR, dated 2/2025, the TAR indicated Resident 2 ' s skin monitoring was started on 2/20/2025. During a review of Resident 3 ' s Admission Record, the Admission Record indicated the facility admitted Resident 3 on 11/14/2023, with diagnoses that included atherosclerosis heart disease (when the blood vessels that carry oxygen and nutrients from the heart to the rest of the body become thick and stiff) unspecified chest pain and cardiomegaly (your heart is larger than it should be). During a review of Resident 3 ' s H&P, dated 7/24/2024, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated Resident 3 ' s cognitive skills for daily decisions was moderately impaired. The MDS indicated Resident 3 needed moderate assistance from staff for toileting and showering. During a review of Resident 3 ' s Physician Order, dated 2/18/2025, the Physician Order indicated monitor skin of generalized body for rashes, papules, and itching. During a review of Resident 3 ' s TAR dated 2/2025, the TAR indicated Resident 3 ' s skin monitoring was started on 2/20/2025. During a concurrent interview and record review on 4/4/2025, at 9:02 a.m., with TN 2, Residents 1, 2, and 3 ' s Physician Order dated 2/18/2025, TAR dated 2/2025 and Progress Notes dated 2/18/2025 to 2/19/2025 were reviewed. TN 2 stated physician ordered the skin monitoring on 2/18/2025 and TAR indicated monitoring was documented starting on 2/20/2025. TN 2 stated they missed two days of skin monitoring from 2/18/2025 to 2/19/2025. TN 2 stated Residents 1, 2, and 3 ' s skin condition can get worst, and residents can be uncomfortable. TN 2 stated it can cause a delay in care and can result in the spread of scabies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/4/2025, at 9:35 a.m., with the IP, the IP stated skin monitoring should be started and documented on the TAR on 2/18/2025. The IP stated there were no documented skin monitoring on Residents 1, 2, and 3 ' s Progress Notes. The IP stated the importance of skin monitoring was to identify change in condition and to report to the physician and give appropriate care and treatment. The IP stated not monitoring the skin and not documenting can cause a delay in the care. During an interview on 4/4/2025, at 11:14 a.m., with the DON, the DON stated nurses should start the monitoring and documentation on 2/18/2025, when the physician made the order. The DON stated the importance of monitoring was to ensure resident's skin was assessed for possible signs of scabies to prevent delay in care. During a review of facility ' s P&P titled, Outbreak of Communicable Diseases, dated 4/2023 and last reviewed on 4/17/2024, the P&P indicated, The Infection Preventionist and the Director of Nursing are responsible for: a. Managing surveillance data. b. Monitoring ill residents and staff, c. Initiating transmission-based precautions, as appropriate. The Nursing staff is responsible for . b. providing infection surveillance data in a timely manner. During a review of facility ' s P&P titled, Scabies- Prevention and Control, undated and last reviewed on 4/17/2024, the P&P indicated, Nurses and other healthcare workers will be trained to recognize and report any patient themselves or other healthcare worker with signs and symptoms compatible with scabies infestation.