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	03/09/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the medical records of one of three sampled residents (Resident 1) was maintained in accordance with accepted professional standards and practice, complete, and accurately documented by failing to ensure licensed nurses documented the level of care provided to Resident 1 while the resident was in the facility. Resident 1's vital signs (essential, objective measurements of basic body functions, used to evaluate physical health, indicate disease, and monitor recovery) were not documented in the resident's medical records during a change of condition (COC) on 2/26/2026. This deficient practice resulted in incomplete information on Resident 1's medical records and had the potential for delayed medical interventions.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 2/7/2026 with diagnoses including metabolic encephalopathy (a temporary or permanent brain dysfunction caused by chemical imbalances in the body rather than a direct physical injury), cerebral infarction (a blockage in the blood vessel that stops oxygen and blood from reaching part of the brain), and unspecified dementia (a mental decline such as memory loss or confusion, that interfere with daily life, but the exact cause cannot be determined). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/14/2026, the MDS indicated Resident 1's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were severely impaired. During a review of Resident 1's COC Assessment Form, dated 2/26/2026, the COC Assessment Form indicated at 10:30 a.m., Resident 1 was observed confused, unable to make eye contact, and staring at the right side. Resident 1's vital signs values were documented in the Background section of the COC Assessment Form. At 12 p.m., Resident 1 was observed with increased weakness on the left side of the body and facial twitching. The COC Assessment Form indicated Resident 1's vital signs were within normal range. There were no documented vital signs values that indicated Resident 1's vital signs were normal. During a telephone interview on 3/9/2026 at 1:56 p.m. with Registered Nurse (RN) 1, RN 1 stated the licensed nurses were monitoring Resident 1 every 15 minutes that included the resident's vital signs. RN 1 stated she did not document the monitoring performed every 15 minutes on Resident 1. RN 1 stated she should document Resident 1's COC progress or decline in the resident's medical record to ensure complete documentation. During an interview on 3/9/2026 at 2:35 p.m. and concurrent record review of Resident 1's medical record, reviewed with the Director of Nursing (DON), the DON stated there was no confirmed documented evidence of Resident 1's vital signs after the resident's second COC at 12 p.m. on 2/26/2026. The DON stated failure to document the resident's vital signs after a COC could result in miscommunication amongst the healthcare team. The DON acknowledged and stated the facility failed to accurately and completely document Resident 1's vital signs following the resident's COC. During a review of the facility's policy and procedure (PnP) titled, Charting and Documentation, last reviewed on 4/16/2025, the PnP indicated all services provided to the resident. or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The PnP indicated documentation in the medical record will be objective, complete, and accurate.

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