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	05/05/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 1) by failing to develop a care plan for tracheostomy tube (a surgically created hole [stoma] in the neck leading directly into the windpipe [trachea] to provide an airway, often using a tube to help with breathing) change after admission on [DATE].This failure had potential for delays in the delivery of necessary care and services to Resident 1.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on 1/30/2026, with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure, malignant neoplasm (a cancerous tumor characterized by uncontrolled cell growth, invasion of surrounding tissues, and the ability to spread [metastasize] to other parts of the body) of lip, oral cavity and pharynx (a hollow, muscular tube in the neck that serves as the throat), with tracheostomy and dependent on ventilator (a medical device to help support or replace breathing).During a review of Resident 1's Order Summary Report, dated 1/30/2026, the Order Summary Report indicated change tracheostomy tube every month starting on the last day of the month and ending on the last day of the month, every month. Start date on 2/28/2026. 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 3/26/2026, 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 4/2/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for oral hygiene, upper body dressing and mobility. The MDS indicated Resident 1 had continuous oxygen therapy (the medical use of extra oxygen delivered through a machine [concentrator] or tank, flowing non-stop into a resident) with tracheostomy and ventilator.During a concurrent interview and record review on 4/30/2026, at 12:30 p.m., with the Director of Nursing (DON), Resident 1's Care Plans were reviewed. The DON stated there should have been a care plan developed for Resident 1's routine tracheostomy tube changes as indicated in the physician order.During an interview on 5/5/2026, at 11:17 a.m., with the DON, facility's policy and procedure (P&P), titled, Comprehensive Person-Centered Care Plan, dated 3/2023, and last reviewed on 4/15/2026, the P&P, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The DON stated the facility failed to develop a care plan for routine tracheostomy tube change as per physician order as scheduled on 2/28/2026, after Resident 1's admission on [DATE]. The DON stated all treatment, and procedure should have a care plan. The (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
	555686	A. Building B. Wing	05/05/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated the care plan list all the interventions that will be provided to Resident 1 to address medical needs. The DON stated that without the care plan it affects the information relayed among staff. The DON stated the comprehensive care plan should have been developed within 21 days after admission of what services will be provided to Resident 1.

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	05/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) who had history of acute and chronic respiratory failure (acute failure happens suddenly [minutes/hours] and is a life-threatening emergency, while chronic failure develops gradually over time due to ongoing lung damage), with tracheostomy (a surgically created opening [stoma] in the front of the neck leading into the trachea [windpipe] to assist with breathing) and dependent on ventilator (a medical device to help support or replace breathing), was provided with respiratory care consistent with professional standards of practice. The facility failed to ensure tracheostomy tube change performed before the 29th day per manufacturers guidelines (instruction manual created by the company that made a product that explains exactly how to install, use, clean, and fix the item safely and correctly) and monthly as per physician order. The facility did not change Resident 1's tracheostomy tube for 75 days since admission to the facility on [DATE]. This deficient practice had the potential to result in complications to Resident 1's tracheostomy tube change. On [DATE], Respiratory Therapist 1 (RT 1) and RT 2 changed Resident 1's tracheostomy tube but could not establish a patent (open, unobstructed, or allowing free passage) airway after three attempts and resulted to Resident 1's cessation (stopping) of breathing and heart rate (HR) on [DATE], at 8:54 a.m., and was pronounced dead on [DATE], at 9:18 a.m.Findings:During a review of Resident 1?s admission Record, the admission Record indicated the facility admitted Resident 1 on [DATE], with diagnoses that included unspecified (unconfirmed) acute and chronic respiratory failure, malignant neoplasm (a cancerous tumor characterized by uncontrolled cell growth, invasion of surrounding tissues, and the ability to spread [metastasize)] to other parts of the body) of lip, oral cavity and pharynx (a hollow, muscular tube in the neck that serves as the throat), with tracheostomy and dependent on ventilator.During a review of Resident 1's Order Summary Report, dated [DATE], the Order Summary Report indicated change tracheostomy tube every month starting on the last day of the month and ending on the last day of the month, every month. Start date on [DATE]. During a review of Resident 1's Order Summary Report, dated [DATE], the Order Summary Report indicated change tracheostomy tube every month starting on the 28th of the month and ending on the 28th every month. Start on [DATE].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 [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Order Summary Report, dated [DATE], the Order Summary Report indicated change tracheostomy tube every month starting on the 26th and ending on the 26th every month. Start date on [DATE].During a review of facility's Tracheostomy Tube Change schedule for 3/2026, the schedule did not include Resident 1.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated [DATE], the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for oral hygiene, upper body dressing and mobility. The MDS indicated Resident 1 had continuous oxygen therapy (the medical use of extra oxygen delivered through a machine [concentrator] or tank, flowing non-stop into a resident) with tracheostomy and ventilator.During a review of Resident 1's Licensed Nurses Note, dated [DATE], timed at 6:21 a.m., the Licensed Nurses Note indicated Resident 1 was in a stable condition, breathing normal with no shortness of breath, tracheostomy in place with no complications.During a review of Resident 1's Respiratory Therapy- Continuous Ventilator Flow Sheet, dated [DATE], timed at 8:01 a.m., the Respiratory Therapy- Continuous Ventilator Flow Sheet indicated Resident 6 was on Synchronized Intermittent Mandatory Ventilation (SIMV- a type of breathing support from a ventilator that combines mandatory [guaranteed] breaths with spontaneous [resident-initiated]) breaths ventilation on two liters per minute, saturating (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 B. Wing	05/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(amount of oxygen the red blood cells are carrying) at 97 percent (%- per one hundred), tracheostomy tube care initiated, insertions achieved but no patent airway achieved, Registered Nurse 1 (RN 1) notified. The Respiratory Therapy- Continuous Ventilator Flow Sheet indicated three attempts all with non-patent airway. Bag-Mask Ventilation (BMV- device used for life-saving technique used in emergency medicine and resuscitation to manually provide oxygen to a patient who is not breathing or not breathing adequately) at 100% applied to the upper airways and at 8:45 a.m., cardiopulmonary resuscitation (CPR- an emergency, life-saving procedure performed when the heart stops beating or breathing ceases. It combines chest compression and rescue breaths to maintain blood flow and oxygenation to vital organs, significantly increasing survival chances during cardiac arrest) performed. The Respiratory Therapy- Continuous Ventilator Flow Sheet indicated paramedics arrived, compression and tracheostomy tube changed attempts continued and with no patent airway formed. The Respiratory Therapy- Continuous Ventilator Flow Sheet indicated before the tracheostomy tube change Resident 1 had a HR of 80 beats per minute (bmp), respiratory rate was 20 breaths per minute, 97% oxygen saturation with rhonchi (low-pitched, rattling, or snoring-like lung sounds heard through a stethoscope [a medical instrument used for listening to internal sounds of the body, particularly the heart, lungs, and intestines], typically caused by mucus or obstruction in the large airways) breath sounds on bilateral lungs. The Respiratory Therapy- Continuous Ventilator Flow Sheet indicated that post (after) tracheostomy tube change Resident 1 had no HR, no respiration and no oxygen saturation with absent bilateral lung sounds with large amount of blood noted.During a review of Resident 1's Change of Condition (COC- a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated [DATE], timed at 10:02 a.m., the COC indicated Resident 1 had full arrest (often called cardiac arrest [is a life-threatening emergency where the heart unexpectedly stops beating or beats too ineffectively to pump blood to the body. The person becomes immediately unconscious, stops breathing normally or stops completely], and loses their pulse) while on tracheostomy reinsertion. The COC indicated the following incidents:8:02 a.m.- Acetaminophen (medication used to treat pain) 30 milliliter (ml one-thousandth of a liter) given via gastrostomy tube (g tube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube to premedicate (to administer medication to a patient before a medical procedure, surgery, or treatment to prepare them for it) resident for monthly routine tracheostomy tube change.8:10 a.m.- Initial vital signs taken and recorded as follows: blood pressure (BP)-116/51milimeters of mercury (mmHg-standard unit of pressure), temperature- 97.2 degrees Fahrenheit, respiratory rate-22 breaths per minute, oxygen saturation 96%.8:42 a.m.- Monthly routine trach change done by two skilled RT (RT 1 and RT 2) at the bedside. During the procedure RT 2 , decannulated (removed) tracheostomy size six extended length (XL) tracheostomy tube cuffed distal extension (TCD), and RT 1 reinserted new tracheostomy tube size six XL TCD using obturator (a curved, stiff plastic or metal guide with a rounded tip that is inserted inside the outer tube during insertion) to prevent trauma, aseptic technique (a set of strict medical practices designed to prevent the transfer of germs during medical procedures) observed, tracheostomy tube 100% inserted with no resistance noted, however upon suctioning (a medical procedure that uses a vacuum device to remove accumulated mucus, saliva, or fluids from the mouth, throat, nose, or trachea), resistance noted indicating blockage on the airways, on ventilator monitor, seen drop of volume to 150-180 ml, and increase of pressure to 70 peak noted, a sign that tracheostomy is not patent. Procedure repeated three times and unsuccessful, on the third time downsized (smaller size) tracheostomy tube size five used, still unsuccessful. Difficulty with bagging (the manual process of providing breathing support to a patient who is not breathing adequately or at all) noted on the tracheostomy tube. Switch bagging to upper airway, tracheostomy tube covered to give full oxygenation to the resident. RN 2 immediately called 911, report provided over the phone. Physician notified. Responsible Party (RP) notified. 8:52 a.m. -noted patient with large amount of blood when suctioned. Trauma is undeniable on the tracheostomy stoma. Continued with upper airway (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 B. Wing	05/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manual breath. with 100% oxygen supplement.8:53 a.m.- vital signs checked, noted deteriorating BP, systolic blood pressure (sbp- the top [first] number in a reading that measures the maximum pressure in your arteries when your heart beats and contracts) at 50 mmHg and the diastolic blood pressure (dbp- the bottom [second] number in a reading, measuring the pressure in your arteries when your heart muscle rests between beats) was unappreciated, HR-20 bpm, oxygen saturation at 50%. Continue to bag resident with 100% oxygen supplement on upper airways.8:54 a.m. HR and BP at this time was unappreciated, chest compression (a lifesaving, emergency technique used to manually pump a person's heart, keeping blood flowing to vital organs when the person stopped breathing or is in cardiac arrest) initiated.8:57 a.m. Paramedics arrived, report provided, took over care, electrocardiogram (EKG- a quick, painless, and noninvasive test that records the electrical signals of the heart to check for heart disease, arrhythmias, and damage) was done upon arrival, with cardiac rhythm reading showing asystole (flatline- is the complete cessation of electrical and mechanical activity in the heart, resulting in no cardiac output and no pulse). Paramedics applied LUCAS mechanical chest compression device (a portable, battery-operated device that provides automatic, consistent high-quality chest compressions). 911 (number to call for emergency response services) instructed RTs to continue with tracheostomy reinsertion.9:02 a.m.-first epinephrine (medication used to increase heart rate, blood flow to muscles, and blood sugar levels) dose given while facility RT attempt to re-insert tracheostomy tube and was unsuccessful.9:04 a.m., another attempt to reinsert tracheostomy tube, but unsuccessful, large amount of blood noted from the tracheostomy.9:07 a.m., second dose of epinephrine given, attempted to reinsert tracheostomy still unsuccessful. Paramedics called General Acute Care Hospital (GACH), consulted emergency room physicians to seek further direction.9:12 a.m., third dose of epinephrine given. 9:17 a.m. Resident 1's pupil (the black hole in the center of the colored part of the eye) was non?reactive (a serious sign indicating that the eye's pathway to the brain, or the brain itself, is damaged, compressed, or not functioning properly).9:18 a.m. Paramedics declare time of death. Pulmonologist (a physician who specializes in diagnosing and treating diseases of the respiratory system, which includes the lungs, airways, and breathing muscles) and Primary Physician (PP) notified. Called RP and made aware.During a review of Resident 1's License Nurses Note, dated [DATE], timed at 2:43 p.m., the License Nurses Note indicated at 8:50 a.m. called 911, and at 9:18 a.m., paramedics declared time of death.During an interview on [DATE], at 11:06 a.m., with RT 1, RT 1 stated on [DATE], just after 8:30 a.m., he (RT 1) went inside Resident 1's room with RT 2 to assist RT 2 with Resident 1's tracheostomy tube change. RT 1 stated he (RT 1) donned (put on) personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) before entering the room, checked Resident 1's oxygen saturation, suctioned the airway, hyperoxygenate (it involves administering higher-than-usual oxygen concentrations of oxygen to elevate oxygen levels in tissues and blood, usually before procedure) and noted airway was patent. RT 1 stated observed blood from the tracheostomy when air was removed from the cuff (the inflatable balloon around the lower end, which seals the trachea when inflated) of the tracheostomy tube. RT 1 stated when RT 2 removed the tracheostomy tube, more blood came out and he (RT 1) had inserted the first attempt using the tracheostomy tube size six. RT 1 stated tracheostomy was inserted with no resistance. RT 1 stated after reinsertion, Resident 1's tracheostomy was connected to in line suction, but the suction tubing would not go through. RT 1 stated there was an occlusion (the state of being closed or blocked). RT 1 stated they connected Resident 1's tracheostomy to the ventilator but the ventilator had a spike in pressure and showed low tidal volume (TV-the amount of air that moves into or out of the lungs during a single, normal, resting breath) between 110-131 ml. RT 1 stated Resident 1's TV was set at 500 ml. RT 1 stated he (RT1) auscultated (to examine a resident by listening to internal body sounds typically using a stethoscope [a medical device for auscultation]) Resident 1's bilateral lungs and no lung sounds heard. RT 1 stated they called Registered Nurse 1 (RN 1) for assistance while RT 2 reinserted the second tracheostomy tube and still with no patency noted. RT 1 stated at this time Resident 1 (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 B. Wing	05/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started to have respiratory distress. and RT 3 came into the room and attempted the third tracheostomy tube insertion. RT 1 stated RT 3 made the third attempt and still not successful in establishing patent airway. RT 1 stated during the third attempt Resident 1 had increased breathing, respiratory distress, started to get cyanotic (a bluish-purple discoloration of the skin, lips, or fingernails caused by a lack of oxygen in the blood), HR dropped until pulse oximeter (non-invasive, clip-on device used to estimate blood oxygen saturation and pulse rate by shining light through the skin) not reading the oxygen saturation and HR, and he (RT 1) could not palpate (feel) a pulse. RT 1 stated RT 2 started the cardiac compression, and he (RT 1) did the second cardiac compression. RT 1 stated it was his (RT 1) first tracheostomy changes with Resident 1.During an interview on [DATE], at 12:13 p.m., with RT 2, RT 2 stated he (RT 2) was the one assigned to do the tracheostomy tube change and he (RT 2) had gathered all the supplies at bedside. RT 2 stated RT 1 assisted him (RT 2) on [DATE], to change Resident 1's tracheostomy tube. RT 2 stated when he (RT 2) deflated (removed the air) the tracheostomy cuff there was a noticeable amount of blood approximately two ml. RT 2 stated RT 1 was able to successfully insert the tracheostomy tube, but they could not get a patent airway. RT 2 stated they had connected the tracheostomy tube to the ventilator but showed high pressure and low TV. RT 2 stated he (RT 2) attempted the second reinsertion and still with no patent airway. RT 1 stated RT 3 came in to do the third attempt and Registered Nurse 1 (RN 1) was already notified. RT 2 stated all three attempts had no patent airway. RT 2 stated after the third attempt RT 4 completely blocked the tracheostomy and used ambubag (a handheld, self-inflating device used to provide positive-pressure ventilation to patients who are not breathing or are breathing inadequately) Resident 1's upper airway when Resident 1 started to crash (a sudden, severe, and unexpected failure of the heart's function or the circulatory system). RT 2 stated when he (RT 2) heard the paramedic sounds, that's when Resident 1's HR stopped and he (RT 2) could not palpate a pulse on Resident 1's left wrist.During an interview on [DATE], at 12:35 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated on [DATE], Certified Nursing Assistant 1 (CNA 1) notified her (LVN 1) to check on Resident 1 and when she (LVN 1) went inside the room, saw Resident 1 responsive, blinking and opening his (Resident 1) eyes. LVN 1 stated the RTs were attempting to reinsert for the second time, so she (LVN 1) notified RN 1. LVN 1 stated she (LVN 1) and RN 1 went to Resident 1's room and Resident 1 was still awake, pulse oximeter on Resident 1's right index finger showed 80%. LVN 1 stated she (LVN 1) observed when Resident 1 was ambubagged, Resident 1 still awake and blinked his (Resident 1) eyes then became unresponsive.During an interview on [DATE], at 1:01 p.m., with RT 4, RT 4 stated on [DATE], she (RT 4) was near Resident 1 room when she (RT 4) heard the call, she (RT 4) walked in and saw RTs 1, 2 and 3, at Resident 1's bedside. Resident 1's eyes were open and appear to be stable. RT 4 stated she (RT 4) started bagging Resident 1 upper airway after the third attempt and Resident 1 still had a pulse.During an interview on [DATE], at 8:49 a.m., with RN 1, RN 1 stated on [DATE], around 8:46 a.m., LVN 1 notified her (RN 1) to go to Resident 1's room and when he (RN 1) responded, saw RT 1 standing on the left side of the bed, RT 2 on the right side inserting the second attempt for tracheostomy tube change and RT 4 on the left side head part of the bed, ambubagging Resident 1 at bedside. RN 1 stated when he (RN 1) responded the RT already failed the first attempt of tracheostomy tube change. RN 1 stated on the third attempt, RN 2 called 911 (emergency response system) at 8:50 a.m. RN 1 stated Resident 1 started declining at 8:53 a.m., with HR around 20, and had shallow breathing (breathing that takes in only a small amount of air). RN 1 stated at 8:54 a.m., Resident 1 had no pulse and no HR, RT 2 started the chest compression. RN 1 stated two paramedics arrived, one at 8:57 a.m. and another at 8:58 a.m. RN 1 stated paramedics applied the LUCAS machine and gave three doses of epinephrine. RN 1 stated paramedics pronounce Resident 1's death at 9:18 a.m. RN 1 stated the facility's policy was to change every 30 days unless there is an order not to change it. RN 1 stated tracheostomy tube had holes and if not changed for more than two months, tissue can grow and can stick on those holes and once removed can cause trauma. RN 1 stated he (RN 1) was not sure when was the last time Resident 1's tracheostomy tube (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 B. Wing	05/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was changed. RN 1 stated any person cannot survive without oxygen for more than five minutes.During an interview on [DATE], at 9:27 a.m., with LVN 2, LVN 2 stated on [DATE], RT 1 asked her (LVN 2) to call RT 3. LVN 2 stated she (LVN 2) was the one who brought the crash cart (a specialized mobile trolley containing emergency, life-saving equipment and medication, designed to be moved quickly to a resident's side during a medical crisis, such as cardiac arrest) by Resident 1's door in case it is needed.During an interview on [DATE], at 9:56 a.m., with the Lead RT, the Lead RT stated it was Resident 1's first tracheostomy change in the facility since his (Resident 1) admission on [DATE]. The Lead RT stated the facility's protocol was to do a monthly routine tracheostomy tube change. The Lead RT stated Resident 1 was transferred out to GACH 2 on [DATE], for Computed Tomography (CT- a non-invasive, painless medical imaging procedure that uses rotating X-rays and computer technology to create detailed, cross-sectional slices of bones, blood vessels, and soft tissues) of the abdomen and readmitted back to the facility on [DATE], and was transferred again on [DATE], for malfunctioning g tube and readmitted back on [DATE].During an interview on [DATE], at 12:30 p.m., with the Director of Nursing (DON), the DON stated Resident 1 was transferred twice to GACH 2 before he (Resident 1) reached the 30th day in the facility so we (DON) assumed his (Resident 1) tracheostomy tube was changed in GACH 2. The DON stated she (DON) was not sure when was the last time the tracheostomy was changed and there was no documented evidence in Resident 1's medical record of when it was changed.During a concurrent interview and record review on [DATE], at 8:42 a.m., with the DON, Resident 1's GACH 1's- Radiation (energy that moves from one place to another in a form that can be described as waves or particles) Oncology (the specialized branch of medicine dedicated to the diagnosis, treatment, and prevention of cancer) Head and Neck New Patient Visit Note (Radiation Notes), dated [DATE], was reviewed. The Radiation Notes indicated Resident 1 was initially diagnosed with squamous cell carcinoma (SCC-a type of cancer that starts as a growth of cells on the skin) of the hard palate (the bony, front portion of the roof of your mouth, located between your upper teeth and the soft palate) in 2015, and underwent radiation in 2016. The Radiation Notes indicated Resident 1 had chemotherapy (a systemic cancer treatment that uses powerful drugs to destroy rapidly dividing cancer cells throughout the body) on 6/2017, to 7/2017, and had bilateral maxillectomy (a surgical procedure to remove all or part of the maxilla [upper jawbone]), excision (surgical removal) of right cheek skin, right mandible coronoidectomy (surgical removal of the mandibular coronoid process, a part of the lower jaw), right suprahyoid (a group of four small muscles located above the hyoid bone in the neck, connecting it to the jaw and skull base) neck dissection (the act of cutting apart or separating tissues), and tracheostomy.During a concurrent interview and record review on [DATE], at 9:27 a.m. with the Lead RT, Tracheostomy Tube Manufacturers Guidelines, dated 6/2013, was reviewed. The Tracheostomy Tube Manufacturers Guidelines indicated the tracheostomy tube and obturator are single patients use medical devices and usage should not exceed 29 days. Frequent and routine changes of the tracheostomy tube and accessory are recommended and should be evaluated by the qualified physician. The Lead RT stated tracheostomy tubes should be changed before the 29th day.During a concurrent an interview and record review on [DATE], at 9:28 a.m., with the DON, facility's policy and procedure (P&P), titled, Tracheostomy Tube Change, last reviewed on [DATE], and the Tracheostomy Tube Manufacturers Guidelines was reviewed. The DON stated the facility is aware that Resident 1's tracheostomy tube was not changed since admission on [DATE], until [DATE], and it was the facility's first attempt to change monthly, and the manufacturers guideline indicated to change before the 29th day. The DON stated the purpose of tracheostomy tube change monthly was for infection control. The DON stated that not changing tracheostomy tube could result in mucus build up.During an interview on [DATE], at 10:23 a.m., with the Lead RT, the Lead RT stated there is a possibility of tissue growth around the tracheostomy tube if tracheostomy was not changed close to 3 months. The Lead RT stated if there was tissue growth, massive bleeding could occur when tracheostomy was removed. The Lead RT also stated it could also cause infection like pneumonia (lung infection) since Resident 1 was on (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 B. Wing	05/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ventilator and could also cause tracheal malasia (a condition characterized by weak cartilage in the windpipe, causing it to collapse or narrow during breathing, coughing, or crying).During an interview on [DATE], at 11:02 p.m. with RT 3, RT 3 stated he (RT 3) attempted the third tracheostomy tube insertion and notice a lot of resistance when connected to ambubag. RT 3 stated if there was resistance it means the tracheostomy tube was not in place. RT 3 stated airway could have shifted reason for the resistance. RT 3 stated on the third attempt they still could not establish the airway.During an interview on [DATE], at 2:12 p.m., with RT 2, RT 2 stated before Resident 1's tracheostomy tube change, Resident 1 was awake, no bleeding from the tracheostomy site and vital signs were normal. RT 2 stated after the three attempts of tracheotomy tube change Resident 1 coded meaning Resident 1 had no pulse and no respiration and was pronounced dead. RT 2 stated the cause of Resident 1's death was that he (Resident 1) deteriorated (worsen) when airway could not be established.During an interview on [DATE], at 3:16 p.m., with RN 2, RN 2 stated she (RN 2) called 911 on [DATE], at 8:50 a.m., as per RN 1 instruction using the facility phone that Resident 1's tracheostomy tube was inserted but not patent. RN 2 stated the paramedics pronounced Resident 1's death at 9:18 a.m.During a concurrent interview and record review on [DATE], at 4:21 a.m., with the DON, the DON provided a Printout from a website on what are the risks of not changing the tracheostomy tube every 29 days. The Printout indicated, The risk of not changing a tracheostomy tube every 29 days includes:1. Infection-accumulation of secretions and mucus can lead to bacterial colonization and infection at the tracheostomy site.2. Airway obstruction-secretions can obstruct airflow, potentially leading to respiratory distress 3. Injury- the inner cannula can become damaged, causing air leakage and discomfort.4. Complications like tracheal stenosis (abnormal narrowing of the windpipe [trachea] due to scar tissue or inflammation, causing breathing difficulties), granulation tissues (the process of building new, temporary connective tissue and tiny blood vessels to fill in a wound from the base upward) and air embolism (a blockage in a blood vessel).The DON stated if tracheostomy tube was not change for more than 29 days, it could cause a block in the airway.During an interview on [DATE], at 11:17 a.m., with the DON, the DON stated the facility failed to change Resident 1's tracheostomy tube as indicated in the manufacturers guidelines and failed to follow the physician order to change monthly. The DON stated Resident 1's tracheostomy tube should have been changed within 29 days and on [DATE], should have been Resident 1's third tracheostomy tube changed. The DON stated the facility should have checked when the last time Resident 1's tracheostomy tube was changed to keep track on when the next change will be. The DON stated since Resident 1's tracheostomy tube was not changed close to 3 months (75 days) Resident 1 could have developed respiratory infection and buildup of secretions. The DON stated it could also result in possible granulation tissue formation causing blockage of the airway. The DON stated on [DATE], the RTs were able to insert the tracheostomy tube but could not establish a patent airway and if there were no patent airway, Resident 1 could get into cardiac pulmonary arrest and eventually die without oxygen.During an interview on [DATE], at 1:06 p.m., with the Pulmonologist, the Pulmonologist stated the standard for tracheostomy tube change was every month. The Pulmonologist stated he (Pulmonologist) ordered tracheostomy tube change every month. The Pulmonologist stated sick person like Resident 1 had less reserve of oxygen in their body. The Pulmonologist stated Resident 1 had a tracheostomy for open airway and was on ventilator to assists him (Resident 1) with breathing.During a review of facility's P&P, titled, Tracheostomy Tube Change, undated and last reviewed on [DATE], the P&P indicated, All residents tracheostomy tube will be routinely changed monthly, unless ordered otherwise by the physician.During a review of an online course titled, Tracheostomy Tube Changes, dated [DATE], the online course indicated, Indications for tracheostomy tube change:There are a variety of reasons for a tracheostomy tube change including: .routine changes as part of the ongoing airway management.Second and subsequent routine tracheostomy changes:There is variability between institutions on when to change a long-term tracheostomy tube. Recommendations are generally inconsistent and unsupported by evidence. (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 B. Wing	05/05/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manufacturers typically recommend 30 days as the maximum amount of time for a double lumen tracheostomy tube to be left in place. Single cannula tracheostomy tubes are recommended to be changed every 7-10 days. The tracheostomy tube should be routinely changed based on the manufacturer's recommendations, because tube materials perish (to be destroyed) and can result in device failure or infection. Another reason to support tracheostomy tube change is the prevention of granulation tissue formation. An observational study has shown that regular tracheostomy tube changes every two weeks can often result in a statistically significant decrease in the number of patients who require surgical intervention for removal of granulation tissue (Yaremchuk, 2003) .Complications of Tracheostomy Tube Change.If there is resistance while passing the suction catheter, this may represent an improperly placed tube.During a review of an online Article titled, Tracheostomy Tube Change, dated [DATE], the article indicated, Tracheostomy tube changes are warranted for a variety of reasons, including confirming the maturation of the transcutaneous tract (especially during the first change), maintaining hygiene and managing the stoma (approximately every 30 days) .Potential contraindications include: . The tube change has a high probability of causing further tissue trauma or bleeding.Clinical significance: Regular tracheostomy tube changes are crucial for patient care. This practice can decrease the risk of complications such as granulation tissue formation, bleeding, and infection.

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	05/05/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure the Lead Respiratory Therapist (Lead RT) maintain accurate and complete record for three of three sampled staff (Registered Nurse 1 [RN 1], Respiratory Therapist 1 [RT 1] and RT 2), by failing:1. To ensure the Lead RT documented and completed RN 1, RT 1 and RT 2's Ventilator and Nebulizer Key Competency Checklist to indicate if the three staff (RN 1, RT 1 and RT 2) were able to demonstrate proper knowledge, use and application of ventilator (a medical device to help support or replace breathing) and handheld nebulizer (HHN- a small machine that turns liquid medicine into a mist that can be easily inhaled).2. To ensure the Lead RT documented the exact date of observation for RN 1, RT 1 and RT 2's tracheostomy (a surgically created hole [stoma] in the neck leading directly into the windpipe [trachea] to provide an airway, often using a tube to help with breathing) tube changes in the annual Tracheostomy Tube Change Competency Checklist.These failures had the potential to affect the necessary care provided to meet residents' needs safely.Findingsa. During a review of RN 1's Key Competency Checklist for Respiratory Care-Hand Held Nebulizer (HHN), dated and signed by RN 1 and the Lead RT on 3/19/2026, the Key Competency Checklist was left blank, The Key Competency Checklist for Respiratory Care- HHN, did not indicate if RN 1 had met or not the ability to safely and effectively perform HHN therapy.During a review of RN 1's Key Competency Checklist for Respiratory Care-Ventilator, dated and signed by RN 1 and the Lead RT on 3/19/2026, the Key Competency Checklist was left blank. The Key Competency Checklist for Respiratory Care-Ventilator, did not indicate if RN 1 had met or not the ability to demonstrate proper knowledge, use and application of the ventilator.During a review of RT 1's Key Competency Checklist for Respiratory Care-HHN, dated and signed by RT 1 and the Lead RT on 4/14/2026, the Key Competency Checklist was left blank and did not indicate if RT 1 had met or not the ability to safely and effectively perform HHN therapy.During a review of RT 1's Key Competency Checklist for Respiratory Care-Ventilator, dated and signed by RT 1 and the Lead RT on 4/14/2026, the Key Competency Checklist was left blank and did not indicate if RT 1 had met or not the ability to demonstrate proper knowledge, use and application of the ventilator.During a review of RT 2's Key Competency Checklist for Respiratory Care-HHN, dated and signed by RT 2 and the Lead RT on 4/14/2026, the Key Competency Checklist was left blank and did not indicate if RT 2 had met or not the ability to safely and effectively perform HHN therapy.During a review of RT 2's Key Competency Checklist for Respiratory Care-Ventilator, dated and signed by RT 2 and the Lead RT on 4/14/2026, the Key Competency Checklist was left blank and did not indicate if RT 2 had met or not the ability to demonstrate proper knowledge, use and application of the ventilator.During a concurrent interview and record on 4/30/2026, at 10:15 a.m., with the Lead RT, RN 1's, Key Competency Checklist for Respiratory Care-Ventilator and HHN dated 3/19/2026, and RT 1, and RT 2's Key Competency Checklist for Respiratory Care-Ventilator and HHN dated 4/14/2026, were reviewed. The Lead RT stated he (Lead RT) left the competency question for ventilator and HHN blank. The Lead RT stated RN 1, RT 1 and RT 2 were competent in ventilator and HHN use but he (Lead RT) did not document that they were competent. The Lead RT stated he (Lead RT) should have completely answered all the questions in the competency checklist to show that RN 1, RT 1 and RT 2 were competent (having the necessary ability, knowledge, skills, or capacity to do something successfully or to a required standard) in the use of the HHN and ventilator.b. During a review of RN 1's Subacute Skills Checklist-Respiratory Care-Validation and Competency for Tracheostomy Tube Change Competency, dated and signed by RN 1 and the Lead RT on 3/19/2026, the Subacute Skills Checklist indicated the Lead RT observed RN 1 for one tracheostomy tube change using the simulator (tools and technologies that create realistic, artificial clinical scenarios for training healthcare professionals) and observed three residents tracheostomy tube change on 3/19/2026.During a review of Tracheostomy Tube Change scheduled for 3/2026, the schedule indicated on 3/19/2026, only one (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 B. Wing	05/05/2026

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident (Resident 2) was on the schedule and had tracheostomy tube change on 3/19/2026.During a review of RT 1's Subacute Skills Checklist-Respiratory Care-Validation and Competency for Tracheostomy Tube Change Competency, dated and signed by RT 1 and the Lead RT on 4/14/2026, the Subacute Skills Checklist indicated the Lead RT observed RT 1 for one tracheostomy tube change using the simulator and observed three resident tracheostomy tube change on 4/14/2026.During a review of RT 2's Subacute Skills Checklist-Respiratory Care-Validation and Competency for Tracheostomy Tube Change Competency, dated and signed by RT 2 and the Lead RT on 4/14/2026, the Subacute Skills Checklist indicated the Lead RT observed RT 2 for one tracheostomy tube change using the simulator and observed three resident tracheostomy tube change on 4/14/2026.During a review of Tracheostomy Tube Change scheduled for 4/2026, the schedule indicated on 4/14/2026, only one resident (Resident 3) was on the schedule and had tracheostomy tube change on 4/14/2026.During a concurrent interview and record review on 4/30/2026, at 10:18 a.m. with the Lead RT, Subacute Skills Checklist-Respiratory Care-Validation and Competency for Tracheostomy Tube Change Competency dated 3/19/2026, for RN 1 and dated 4/14/2026, for RT 1 and RT 2 were reviewed. The Lead RT stated he (Lead RT) documented one date for all four observations of tracheostomy tube change. The Lead RT stated he (Lead RT) should have documented the exact date he (Lead RT) observed the tracheostomy tube change. The Lead RT stated the dates of observation were inaccurate. The Lead RT stated the importance of accurate documentation was for tracking and maintaining accurate staff records. The Lead RT stated he (Lead RT) got lazy documenting the exact dates reason why there was only one date for all four tracheostomy tube change observation for the three staff (RN 1, RT 1 and RT 2).During an interview on 5/1/2026, at 9:28 a.m., with the Director of Nursing (DON), the DON stated the Lead RT should completely answer the competency checklist for ventilator and HHN and should have documented exact date of observation for tracheostomy tube changes. The DON stated if the competency was incomplete, it would show that the three staff (RN 1, RT 1 and RT 2) were not trained and competent on the ventilator, HHN and tracheostomy tube changes. The DON stated it would show inaccurate competency checklist and could create confusion in staff record.During a review of the Lead RT's Job Description, signed and dated by the Lead RT on 7/16/2024, the Job Description indicated, Supervisory Responsibilities: Directly supervises the Respiratory Therapist. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws. Responsibilities include, interviewing, hiring, and training employees; planning, assigning and directing work; appraising performance; rewarding and disciplining employees; addressing complaints and resolving problems.Competencies: To perform the job successfully, an individual should demonstrate the following competencies: .Professionalism: .Follows through on commitments.Quality: Demonstrates accuracy and thoroughness.

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	05/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement its infection control measures for one of three sampled residents (Resident 2) by failing to ensure Registered Nurse 3 (RN 3) wore gown when suctioning Resident 2 who had a tracheostomy tube and on Enhance Barrier Precaution (EBP- infection control measures for high-risk residents, to reduce the spread of multidrug-resistant organism [MDRO- Bacteria that resist treatment with more than one antibiotic]).This failure had the potential for cross contamination (unintentional transfer of bacteria or germs or other contaminant from one surface to another) and spread infections and illnesses to residents, and staff.Findings:During a review of Resident 2?s admission Record, the admission Record indicated the facility admitted Resident 2 on 4/7/2012, with diagnoses that included chronic respiratory failure (a long-term condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide, often lasting over a month) with tracheostomy (a surgically created hole [stoma] in the neck leading directly into the windpipe [trachea] to provide an airway, often using a tube to help with breathing) and gastrostomy tube.During a review of Resident 2's Physician Order, dated 7/22/2025, the Physician Order indicated EBP manifested by resident with ventilator, tracheostomy and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube feeding.During a review of Resident 2's Care Plan, dated 7/22/2025, the Care Plan regarding EBP indicated provide EBP gloves, gown and mask.During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 3/26/2026, 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 had a feeding tube and tracheostomy tube.During a review of Resident 2's Subacute Pulmonary Progress Notes, dated 4/22/2026, the Subacute Pulmonary Progress Notes indicated Resident 2 did not have the capacity to understand and make decisions.During an observation on 4/29/2026, at Resident 2's bedside. Observed an EBP signage posted outside of Resident 2's door that indicated, Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities. Device care or use. tracheostomy. Observed RN 3 don (put on) gloves and went inside Resident 2's room and pulled the curtain close.During a concurrent observation and interview on 4/29/2026, at 9:04 a.m., with RN 3 at Resident 2's bedside. Observed RN 3 wearing gloves and mask, no gown, suctioned Resident 2's tracheostomy tube. RN 3 stated he (RN 3) suctioned Resident 2's secretion from the tracheostomy tube.During an interview on 4/29/2026, at 11:47 a.m., with the Infection Preventionist (IP), the IP stated residents with open areas like wound, urinary catheter (a hollow tube inserted into the bladder to drain or collect urine), ventilator (a medical device to help support or replace breathing), tracheostomy and gastrostomy tube were on EBP. The IP stated all residents on Subacute were on EBP. The IP stated any direct contact with residents on EBP should wear gloves and gown. The IP stated suctioning Resident 2 is a direct contact and RN 3 should have worn a gown when suctioning Resident 2. The IP stated wearing gown minimize the spread of infection to residents. The IP stated the care plan was not followed.During an interview on 4/29/2026, at 12:47 p.m., with the Director of Nursing (DON), the DON stated residents in Subacute were all placed on EBP because they are all high-risk residents for infection.During an interview on 5/1/2026, at 9:28 a.m., with the DON, the DON stated the facility failed to ensure RN 3 wore a gown when suctioning Resident 2 who was on EBP. The DON stated there is a possible spread of infection because gown was not used.During a concurrent interview and record review on 5/5/2026, at 11:17 a.m., with the DON, facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 8/2022, and last reviewed on 4/15/2026, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do (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 B. Wing	05/05/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not otherwise apply. a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room).3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: . g. device care or use (central line [a long, flexible, soft tube inserted into a large vein-usually in the neck, chest, or arm that extends down to a major vein near the heart], urinary catheter, feeding tube, tracheostomy/ventilator); .10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) required. The DON stated RN 3 should have worn the gown while suctioning Resident 2 who was on EBP.