STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555707	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Imperial Care Center	11441 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (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

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pain management was provided to one of three sampled residents (Resident 2) when there was no documented evidence in Resident 2's medical record showing Licensed Vocational Nurse (LVN 3) had assessed Resident 2's reported pain on 6/29/2025. This failure had the potential to result in Resident 2's reported pain to be left unmanaged which can prevent Resident 2 from reaching her highest practicable wellbeing.Findings: During a review of Resident 2's admission Record, dated 7/7/2025, the admission Record indicated Resident 2's diagnoses included polyneuropathy (a condition where nerves running along the arms, hands, legs, and feet are damaged causing pain, weakness, numbness, and tingling), and osteoarthritis (a joint condition where the cartilage between bones wears down, causing pain, stiffness, and decreased movement) of both knees. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 6/13/2025, the MDS indicated Resident 2 is usually understood but occasionally has difficulty communicating some words. The MDS indicated Resident 2 is usually able to comprehend most conversation. During a review of Resident 2's care plan, dated 7/2/2025, the care plan indicated Resident 2 has potential for [a]lteration in Comfort/Pain related to [a]dvanced aging and osteoarthritis. The care plan indicated interventions include assess[ing] characteristics of pain and administer[ing] medication as ordered. During a concurrent observation and interview on 7/8/2025 at 2:57 p.m. with Resident 2 in the activities room, Resident 2 was sitting in a recliner wheelchair. Resident 2 stated that sometimes she has pain in her knees which she rates 5 out of 10 on a pain scale (a tool used to describe the intensity of pain, typically ranging from 0 which represents no pain, and up to 10 which represents the highest pain possible). Resident 2 stated her knee pain can reach as high as 10 out of 10. Resident 2 touched both of her knees and stated sometimes both knees have pain at the same time. Resident 2 stated: I call [the nurses] only if I really, really need them, and when I can't stand the pain no more. Resident 2 stated she remembers having pain at the end of last month on her knees all the way down to [her] toes. Resident 2 stated she had asked for pain medication but does not recall if any nurse gave her medication. During a review of Resident 2's Medication Administration Record (MAR), dated 7/8/2025, the MAR indicated Resident 2's doctor ordered 2 tablets of Tylenol 325 milligrams every 6 hours for mild pain rated 1-3 out of 10, and 2 tablets of Tylenol 500 milligrams every 6 hours for moderate pain rated 4-6 out of 10. During an interview on 7/8/2025 at 3:53 p.m. with LVN 2, LVN 2 stated: I remember [Resident 2] reported pain directly to me approximately the end of June. LVN 2 stated she was walking in the hallway near Resident 2's room when LVN 2 heard Resident 2 yell Help!. LVN 2 entered Resident 2's room and asked what was wrong. LVN 2 stated Resident 2 reported pain in both knees and requested pain medication. LVN 2 stated: I told [Resident 2] that I would tell the charge nurse who was assigned to Resident 2. LVN 2 stated she reported Resident 2's pain to LVN 3 and asked if any pain medication had been given to which LVN 3 stated no. LVN 2 stated: I reported to [LVN 3] and said go check her out and see if there is anything you can give her for pain. LVN 2 stated she did not observe LVN 3 enter Resident 2's room to assess for pain or administer any pain medication. During a concurrent interview and record review on 7/8/2025 at 4:00 p.m. with LVN 2, Resident 2's MAR, dated 6/1/2025 to 6/30/2025, was reviewed. LVN 2 stated the pain assessment section in Resident 2's MAR indicated that LVN 3 was assigned to Resident 2 only once during the last week of June, which was on 6/29/2025. LVN 2 stated the MAR indicated LVN 3 documented a pain level of zero for Resident 2 on 6/29/2025, however it is unknown when that pain level was assessed since the MAR does not list the exact time. LVN 2 stated Resident 2's MAR indicated no pain medication was administered to Resident 2 during the entire last week of June 2025, consisting of 6/22/2025 through 6/31/2025. LVN 2 stated pain management is important because if we don't control it, it gets worse. LVN 2 stated pain can't be taken lightly because it can cause other issues and harm. During a phone interview on 7/9/2025 at 9:57 a.m. with LVN 3, LVN 3 stated he worked on 6/29/2025 and was assigned to Resident 2. LVN 3 stated LVN 2 informed him that Resident 2 had reported pain and requested medication. LVN 3 stated: I do remember that incident. LVN 3 stated he was currently passing medications to a different resident at the time of LVN 2's reporting. LVN 3 stated approximately 10 minutes later, LVN 3 entered Resident 2's room to assess for pain but found Resident 2 asleep. LVN 3 stated he visually checked Resident 2 later during LVN 3's shift but Resident 2 remained asleep. When asked where in Resident 2's records indicate LVN 3 assessed Resident 2's reported pain, LVN 3 stated: For this instance, I didn't

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was free from a significant medication error when Licensed Vocational Nurse (LVN 1) was about to administer Gabapentin (a medication that prevents/controls seizures and can also relieve nerve pain) without first checking Resident 1's respiration rate (the amount of breaths a person takes per minute) per the doctor's order. This failure had the potential to result in an adverse effect (undesired effect of a drug or other type of medical treatment) from taking Gabapentin, which can significantly decrease respirations (the process of breathing air in and out of the lungs). Findings: During a review of Resident 1's admission Record, dated 7/9/2025, the admission Record indicated Resident 1's diagnoses include dementia (a decrease in thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life), neuralgia (pain caused by irritation or damage to a nerve), and neuritis (inflammation of a nerve causing pain, numbness, tingling, or weakness). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 1's ability is limited in making concrete requests. The MDS indicated Resident 1 comprehends most conversation. The MDS also indicated Resident 1 has functional limitations to the lower extremities, which consists of the hips, knees, ankles and feet. During an observation on 7/3/2025 at 12:53 p.m. in Resident 1's room, Resident 1 was sitting in a recliner wheelchair. LVN 1 entered Resident 1's room and advised Resident 1 that Gabapentin will be given. LVN went to the medication cart in front of Resident 1's room and began preparing the medication by unscrewing the Gabapentin capsules in order to mix the powdered medication with applesauce. LVN 1 returned to Resident 1 and was observed to be holding a spoonful of applesauce mixed with the medication. LVN 1 was about to feed the spoonful of applesauce to Resident 1, when LVN 1 was asked by surveyor to stop and step out of Resident 1's room. During a concurrent interview and record review on 7/3/2025 at 12:58 p.m. with LVN 1, Resident 1's Medication Administration Record (MAR), dated 7/3/2025 was reviewed. LVN 1 was asked if Resident 1's doctor had ordered any parameters (instructions ordered by a doctor regarding when to give or hold medication) to be checked before administering Gabapentin. LVN 1 stated the MAR indicated to hold if respiration rate is less than 12 and to notify MD. LVN 1 stated Resident 1's respiration rate was not checked in surveyor's presence because Resident 1's respirations were checked 15 minutes ago, but LVN 1 didn't put it in the computer and save. LVN 1 stated Resident 1's respiration rate should have been checked at the moment medication is about to be administered because it is safer and more accurate per standard nursing practice. LVN 1 stated the respiration rate must be accurately assessed to ensure it is safe to give the Gabapentin to Resident 1 per the doctor's orders. During an interview on 7/9/2025 at 12:02 p.m. with Director of Nursing (DON), DON stated parameters are part of a doctor's order. DON stated if a licensed nurse administers a medication, such as Gabapentin, without checking the parameters, it is considered a significant medication error because you have to follow the doctor's order. DON stated the consequence of failing to check parameters prior to administering Gabapentin is the possibility that the medication can cause respiratory distress and harm to the resident. During a review of the facility's policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, dated 7/2024, the P&P indicated a medication error is defined as the preparation or administration of drugs.which is not in accordance with physician's order. The P&P also indicated an adverse consequence is an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's.physical condition. The P&P indicated that staff and practitioner shall strive to minimize adverse consequences resulting from medication errors.

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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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medical record of one of three sampled residents (Resident 2) was complete, accurately documented, and contained a record of Resident 2's pain assessments when Licensed Vocational Nurse (LVN 3) stated Resident 2's pain was assessed on 6/29/2025 after Resident 2 reported pain to both knees. This failure resulted in an incomplete medical record as there was no documented evidence that Resident 2's reported pain was addressed.Findings: During a review of Resident 2's admission Record, dated 7/7/2025, the admission Record indicated Resident 2's diagnoses included polyneuropathy (a condition where nerves running along the arms, hands, legs, and feet are damaged causing pain, weakness, numbness, and tingling), and osteoarthritis (a joint condition where the cartilage between bones wears down, causing pain, stiffness, and decreased movement) of both knees. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 6/13/2025, the MDS indicated Resident 2 is usually understood but occasionally has difficulty communicating some words. The MDS indicated Resident 2 is usually able to comprehend most conversation. During a review of Resident 2's care plan, dated 7/2/2025, the care plan indicated Resident 2 has potential for [a]lteration in Comfort/Pain related to [a]dvanced aging and osteoarthritis. The care plan indicated interventions include assess[ing] characteristics of pain and administer[ing] medication as ordered. During a concurrent observation and interview on 7/8/2025 at 2:57 p.m. with Resident 2 in the activities room, Resident 2 was sitting in a recliner wheelchair. Resident 2 stated that sometimes she has pain in her knees which she rates 5 out of 10 on a pain scale (a tool used to describe the intensity of pain, typically ranging from 0 which represents no pain, and up to 10 which represents the highest pain possible). Resident 2 stated her knee pain can reach as high as 10 out of 10. Resident 2 touched both of her knees and stated sometimes both knees have pain at the same time. Resident 2 stated: I call [the nurses] only if I really, really need them, and when I can't stand the pain no more. Resident 2 stated she remembers having pain at the end of last month on her knees all the way down to [her] toes. Resident 2 stated she had asked for pain medication but does not recall if any nurse gave her medication. During a review of Resident 2's Medication Administration Record (MAR), dated 7/8/2025, the MAR indicated Resident 2's doctor ordered 2 tablets of Tylenol 325 milligrams every 6 hours for mild pain rated 1-3 out of 10, and 2 tablets of Tylenol 500 milligrams every 6 hours for moderate pain rated 4-6 out of 10. During an interview on 7/8/2025 at 3:53 p.m. with LVN 2, LVN 2 stated: I remember [Resident 2] reported pain directly to me approximately the end of June. LVN 2 stated she was walking in the hallway near Resident 2's room when LVN 2 heard Resident 2 yell Help!. LVN 2 entered Resident 2's room and asked what was wrong. LVN 2 stated Resident 2 reported pain in both knees and requested pain medication. LVN 2 stated: I told [Resident 2] that I would tell the charge nurse who was assigned to Resident 2. LVN 2 stated she reported Resident 2's pain to LVN 3 and asked if any pain medication had been given to which LVN 3 stated no. LVN 2 stated: I reported to [LVN 3] and said go check her out and see if there is anything you can give her for pain. LVN 2 stated she did not observe LVN 3 enter Resident 2's room to assess for pain or administer any pain medication. During a concurrent interview and record review on 7/8/2025 at 4:00 p.m. with LVN 2, Resident 2's MAR, dated 6/1/2025-6/30/2025, was reviewed. LVN 2 stated the pain assessment section in Resident 2's MAR indicated that LVN 3 was assigned to Resident 2 only once during the last week of June, which was on 6/29/2025. 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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 infection prevention and control in one of four sampled residents (Resident 1) when Licensed Vocational Nurse (LVN 1) prepared to administer Gabapentin (a medication that prevents/controls seizures and can also relieve nerve pain) without first washing hands or using alcohol hand sanitizer per the facility's protocol. This failure had the potential to result in spreading infection to Resident 1 during the administration of Gabapentin. Findings: During a review of Resident 1's admission Record, dated 7/9/2025, the admission Record indicated Resident 1's diagnoses include dementia (a decrease in thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life), neuralgia (pain caused by irritation or damage to a nerve), and neuritis (inflammation of a nerve causing pain, numbness, tingling, or weakness). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 1's ability is limited in making concrete requests. The MDS indicated Resident 1 comprehends most conversation. The MDS also indicated Resident 1 has functional limitations to the lower extremities, which consists of the hips, knees, ankles and feet. During an observation on 7/3/2025 at 12:53 p.m. in Resident 1's room, LVN 1 entered Resident 1's room and advised Resident 1 that Gabapentin will be given. LVN went to the medication cart in front of Resident 1's room and began preparing the medication by unscrewing two Gabapentin capsules in order to mix the powdered medication with applesauce. LVN 1 was not observed to have washed hands or used alcohol hand sanitizer prior to preparing and handling the Gabapentin capsules. During a review of Resident 1's Medication Administration Record (MAR), dated 7/3/2025, the MAR indicated Resident 1's doctor ordered Gabapentin Capsule 100 milligrams and to give 2 capsules by mouth three times a day for neuropathy. During an interview on 7/3/2025 at 4:03 p.m. with LVN 1, LVN 1 stated handwashing or alcohol hand sanitizing did not occur prior to LVN 1 holding and taking apart the Gabapentin capsules so that the powdered medication can be mixed with applesauce. LVN 1 stated handwashing had occurred downstairs when [LVN 1] went there to get medicine cups prior to preparing medications for Resident 1. When asked if LVN 1 took the elevator to come back up to Resident 1's room, LVN 1 stated: No, I used the stairs. LVN 1 stated he had to touch the doorknobs leading to and away from the staircase in order to arrive at Resident 1's room. LVN 1 stated it is possible to spread infection from touching the doorknobs and then proceeding straight to handling Resident 1's medications. During an interview on 7/9/2025 at 12:02 p.m. with Director of Nursing (DON), DON stated before licensed nurses prepare and handle medications with their bare hands, they must wash their hands. DON stated if nurses do not handwash or sanitize prior to medication preparation and administration, the negative outcome would be the possibility of spreading infection. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 7/2024, the P&P indicated [t]his facility considers hand hygiene the primary means to prevent the spread of infection. The P&P indicated [a]ll personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The P&P indicated alcohol-based hand rub containing at least 62% alcohol; or, alternative, soap. and water is to be used before preparing or handling medications.