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	12/23/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 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 interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) received care in accordance with professional standards of practice to attain or maintain the highest practicable physical well-being, when Registered Nurse (RN 2) and RN 3 failed to complete the admission assessment timely when Resident 1 was re-admitted to the facility on [DATE]. This deficient practice had the potential to result in Resident 1 receiving inadequate care. Findings: During a review of Resident 1's admission Record, dated 01/02/2026, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was most recently re-admitted on [DATE]. The admission Record indicated Resident 1's diagnoses included dementia (a decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, language, judgment, and behavior), bipolar disorder (a mental health condition that causes extreme shifts in mood, energy levels, and behavior), and schizoaffective disorder (a mental illness that mixes symptoms of schizophrenia, such as hallucinations, delusions, and disorganized thinking, with symptoms of intense mood swings). During a review of Resident 1's History and Physical Examination (H&P - a comprehensive assessment of a resident's medical condition), dated 07/10/2025, the H&P indicated Resident 1 does 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 10/30/2025, the MDS indicated Resident 1 needed moderate assistance for personal hygiene, shower/bathe, and lower body dressing (a helper does less than half the effort of the activity). The MDS indicated Resident 1 needed supervision or touching assistance for toileting, oral hygiene, and upper body dressing (a helper provides verbal cues or touching assistance throughout the activity or intermittently). During a review of Resident 1's Change of Condition (COC - when a resident experiences any physical, mental, or psychosocial change from his/her baseline status), dated 12/09/2025, the COC indicated that on 12/09/2025 at 4 a.m., Resident 1 was found at the end of the hall banging his walker against the facility doors attempting to break and exit [the] facility. Staff attempted [to] redirect, however unsuccessful due to [Resident 1] lashing out at staff and becoming verbally and physically aggressive. [Resident 1] proceeded down the hall ignoring de-escalation attempts by staff and proceeded to [NAME] the walker against the walls and paintings on the wall. The COC further indicated that 911 [was] called for transport to the hospital for evaluation and for being a danger to [Resident 1's self] and others. During a phone interview on 12/23/2025 at 10:45 a.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated when he began his shift on 12/08/2025 at approximately 11 p.m., he found Resident 1 asleep and sitting in a chair in front of the nursing station. CNA 1 stated he assisted Resident 1 back to his room to lay on his bed. CNA 1 stated that at approximately 3 a.m., another resident started to yell and scream and that was enough to [wake up Resident 1. CNA 1 stated when CNA 1 returned from his break, another CNA (which CNA 1 could not recall) had changed Resident 1's adult diaper. CNA 1 stated he saw Resident 1 walking around with his walker at about 4 a.m. CNA 1 stated he then heard Resident 1 mad and crashing the back door with his walker. CNA 1 stated he saw numerous staff members approach Resident 1, but CNA 1 was unable to assist because he was preoccupied with another resident. CNA 1 stated he remembers RN 2 calling 911 because Resident 1 took his walker and tried to hit people. CNA 1 stated staff members tried to offer [Resident 1] cookies or juice but it didn't work. CNA 1 stated he saw Resident 1 spit on one of the CNAs. CNA 1 stated Resident 1 only calmed down when he saw the police, and Resident 1 was then transferred to an acute hospital. CNA 1 stated he recalls Resident 1 was re-admitted to the facility on [DATE] around 2 p.m. to 3 p.m. During an interview on 12/23/2025 at 11:47 a.m. with RN 1, RN 1 stated an admission assessment is completed when a resident is admitted or re-admitted to the facility. RN 1 stated that a registered nurse can endorse (give the task to the next shift to complete) other assessments like fall risk, dehydration, skin if [the RN does not] have time to finish those, but the priority is the admission assessment and obtaining doctor's orders when a resident returns to the facility from an acute hospital. RN 1 stated the importance of timely completing the admission assessment is to get a baseline of your patient from head to toe so you know where they start when they arrive. During a concurrent interview and record review on 12/23/2025 at 12:03 p.m. with RN 1, Resident 1's electronic medical record was reviewed. RN 1 stated Resident 1's clinical admission assessment was completed on 12/23/2025 at approximately 3 a.m. by the night shift nurse. RN 1 stated there was no licensed nursing note regarding Resident 1's re-admission on [DATE] in the afternoon. RN 1 stated the clinical admission assessment should have been documented on