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	04/10/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent a fall and injury for one of three sampled residents (Resident 1), who was confused, identified as a high fall risk, had difficulty in walking, and had repeated falls in the facility. Resident 1 required the use of an assistive device (a tool or piece of equipment that helps a person with disability perform tasks and activities such as a walker [a device that helps a person maintain balance and stability while walking]) and needed supervision to prevent falls and injuries. The facility failed to: 1. Add Resident 1 to the Falling Star Program (a resident safety initiative that uses a visual symbol, like a falling star, to identify residents at high risk for falls in healthcare settings) after identifying Resident 1 as high risk for falls after fall incidents in the facility on 2/4/2026 and 2/8/2026 in accordance to the facility's policy and procedure (P&P) titled, Falling Star Program. 2. Provide front-wheel walker (FWW or two-wheel walker - a mobility aid with wheels on the front two legs and rubber tips or glides on the back two legs that helps provide stability and balance while walking) to Resident 1 per care plan titled, Resident at Risk for Recurrent Falls/Injury. and per Physical Therapist (PT- a health professional trained to evaluate and treat people who have conditions or injuries that limit their ability to move and do physical activities) recommendations on 2/6/2026 (after Resident 1's fall on 2/4/2026) and on 2/9/2026 (after Resident 1's fall on 2/8/2026). 3. Follow Resident 1's plan of care to encourage the use of wheelchair, frequent visual monitoring, and provide resident with assistive device per Resident 1's care plan titled, Resident at Risk for Recurrent Falls/Injury. 4. Provide supervision or touching assistance (helper provides verbal cues and/or touching /steadying and/or contact guard assistance as resident completes activity and assistance may be provided throughout the activity or intermittently) from staff with walking as indicated in Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/31/2025. As a result, on 3/30/2026 at 1:45 p.m., Resident 1 fell in the facility's hallway while walking unsupervised, without using an FWW or a wheelchair. Resident 1 sustained moderate bleeding from the bridge of the nose, anterior scalp laceration (a tear in the skin and underlying soft tissues located on the forehead or frontal hairline region), forehead hematoma (localized collection of clotted blood beneath the skin), and facial swelling. The laceration measured two centimeters (cm - unit of measurement) in length, one cm in width, and 0.2 cm in depth. The forehead hematoma measured three cm in length and 3 cm in width. Licensed Vocational Nurse (LVN) 1 applied a dressing (a pad or cover applied to an injury or wound to protect it, promote healing and prevent infection) on Resident 1's laceration. Resident 1 reported pain at a level of six out of 10 (moderate to severe or distressing pain that cannot be ignored for any length of time) using the numerical rating pain scale (tool used to measure pain intensity with zero meaning no pain and 10 meaning worst possible pain). On 3/30/2025 at 2:40 p.m., the facility transferred Resident 1 to General Acute Care Hospital (GACH) 1 for further evaluation and management where Resident 1 was diagnosed with a nasal (nose) fracture, mild left frontal scalp hematoma (a localized collection of blood that forms under the skin on the upper left forehead following minor trauma), and blunt head trauma (a non-penetrating impact causing the brain to shift or jolt within the skull without breaking the skull).Findings: During a review (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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F 0689 Level of Harm - Actual harm Residents Affected - Few	of Resident 1's Face Sheet (admission Record), the Face Sheet indicated the facility originally admitted Resident 1 on 2/5/2019 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities including memory, thinking, and behavior severe enough to interfere with daily life), difficulty in walking, rheumatoid arthritis (a chronic, autoimmune disorder where the immune system attacks joint linings, causing painful swelling, stiffness, and potential deformity, primarily in the hands, wrists, feet, knees, and ankles), pain in unspecified joint, and hypotension (low blood pressure). During a review of Resident 1's care plan titled, Resident at Risk for Recurrent Falls/Injury, related to: . Dementia, poor safety awareness, . unsteady gait (is the specific pattern or manner of walking, running, or moving on foot, which is complex ., initiated on 5/17/2024, the care plan indicated a goal of reducing Resident 1's risk of falls and injury with the following interventions: - Rehabilitation (Rehab) Department (a specialized medical unit focused on restoring, maintaining, or improving a person's physical, mental, or cognitive [the mental process of acquiring knowledge, understanding, and processing information through thought, experience, and the senses] functioning lost due to injury, illness, or disability) to re-assess the resident. PT started on 2/5/2026. Continue with rehabilitation therapy (ongoing, post-acute phase of care designed to sustain, reinforce, and build upon the functional gains achieved during initial, intensive treatment) and use FWW. - Encourage to use wheelchair due to weakness. - Frequent visual monitoring. - Provide resident with assistive device. During a review of Resident 1's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 5/1/2025, the H&P indicated Resident 1 was confused and unable to make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1 had impaired cognition (a decline in a resident's mental abilities, impacting their ability to think, learn, remember, reason, and make decisions). The MDS indicated that for mobility (movement) Resident 1 required supervision or touching assistance from staff with walking 10 feet (unit of measurement) indicating once standing, the resident had the ability to walk at least 10 feet (in a room, corridor or similar spaces), walking 50 feet with two turns (once standing, the ability to walk at least 50 feet and make two turns, and walking 150 feet (once standing, the ability to walk at least 150 feet in a corridor or similar space). During a review of Resident 1's COC (Change of condition - a decline or improvement that requires assessment, often prompting a revision of the care plan)/Interact Assessment Form, dated 2/4/2026 timed at 11:04 a.m., the COC/Interact Assessment form indicated that on 2/4/2026 Resident 1, who was alert to self only (a clinical assessment indicating a person knows their name and identity but disoriented to time, place, or event) and confused, was observed lying on the floor on her (Resident 1) right side in the hallway, complained of mild head pain with a score of three out of 10 (noticeable and distracting mild pain) using the numerical rating pain scale and noted with swelling at the back of her (Resident 1) head. The COC/Interact Assessment form indicated the Medical Doctor (MD) ordered Tylenol (acetaminophen with dose not indicated - a widely used over-the-counter drug that relieves mild-to-moderate pain and reduces fever) and was administered to Resident 1. The COC/Interact Assessment form indicated the facility transferred Resident 1 through ambulance to GACH 1 for Computed Tomography (CT) head evaluation (a fast, noninvasive medical procedure that create detailed images of the brain, skull, and sinuses commonly used in emergencies to quickly identify bleeding, blood clots, swelling, tumors, or fractures [broken or cracked bones]). During a review of Resident 1's Fall Risk Observation/Assessment form, dated 2/4/2026, the form indicated Resident 1's fall risk score after a fall on 2/4/2026 was 10 (a score ranging from 10 and above signifies a high risk for falls). During a review of Resident 1's Rehab Fall Risk Assessment (a tailored evaluation by healthcare providers to identify an individual's likelihood of falling, typically focusing on balance, strength, and mobility), dated 2/6/2026 timed at 2:32 p.m., the Rehab Fall Risk Assessment indicated on 2/4/2026 Resident 1 fell in the hallway and was transferred to GACH 1. The Rehab Fall Risk Assessment indicated Resident 1 was not using any assistive device, had limited ambulation, and the facility introduced FWW as an ambulation device to Resident 1 as the resident was not using any (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	ambulation device before. During a review of Resident 1's COC/Interact Assessment Form, dated 2/8/2026 timed at 12:50 p.m., the COC/Interact Assessment form indicated Resident 1, who was alert to self only and confused, was observed lying on the floor in the upstairs' dining room on 2/8/2026 at 12:50 p.m., complained of mild head pain with a score of three out of 10 using the numerical rating pain scale. The COC/Interact Assessment form indicated the physician ordered Tylenol (dose not indicated) and was administered to Resident 1. The COC/Interact Assessment form indicated an ice pack was applied to Resident 1's head.During a review of Resident 1's Fall Risk Observation/Assessment form, dated 2/8/2026, the form indicated Resident 1's fall risk score after a fall on 2/8/2026 was 10. During a review of Resident 1's Rehab Fall Risk Assessment, dated 2/9/2026 timed at 12:04 p.m., the Rehab Fall Risk Assessment indicated on 2/8/2026 Resident 1 fell, while trying to stand up, in the dining room. The Rehab Fall Risk Assessment indicated the PT recommended the use of FWW as an ambulation device to Resident 1. The Rehab Fall Risk Assessment indicated recommendations on the use of wheelchair and lap buddy (a soft, cushioned device to fit across a person's lap while they are seated in a wheelchair) and that Resident 1 needed to walk only with therapist with FWWW at this moment due to weakness. During a review of the facility-provided video clip, dated 3/30/2026 at 1:44 p.m., the video clip showed Resident 1, who was wearing a red jacket, dark pants, and black shoes, was walking in the hallway unsupervised (with no staff around to assist Resident 1) and with no assistive device, fell forward hitting her (Resident 1) face on the floor. During a review of Resident 1's COC/Interact Assessment form, dated 3/30/2026 timed at 2:23 p.m., the COC/Interact Assessment form indicated that on 3/30/2026 at 1:45 pm, Resident 1 had a fall in the hallway in the facility. The COC/Interact Assessment form indicated LVN 1 found Resident 1 sitting on the floor with moderate bleeding noted to the bridge of Resident 1's nose and had minimal facial swelling on the right side of the face with pressure and ice applied. The COC/Interact Assessment indicated that Resident 1 complained of six out of 10 pain level (classified as moderate to severe or moderately stronger pain) to the nose and was administered Tylenol 1,000 milligrams (mg - unit of measurement). The COC/Interact Assessment indicated that Resident 1 suffered a slight cut noted on the bridge of the nose, nose, and forehead with swelling. The COC/Interact Assessment indicated the MD ordered to transfer Resident 1 to GACH 1. The COC/Interact Assessment indicated Resident 1 was transferred to GACH 1 on 3/30/2026 at 2:40 p.m. During a review of Resident 1's GACH Radiology Report (a formal document with a detailed, written analysis of findings and offers a clinical impression [a qualified healthcare professional's preliminary, expert opinion regarding a patient's condition), dated 3/30/2026 at 4:35 p.m., the Radiology Report indicated a CT head exam without contrast (without iodine dye [clear and colorless fluid that is used to differentiate certain areas of the body from surrounding tissues) was performed because of acute (sudden onset) headache, fall, nasal contusion (bruise [is a discoloration of the skin caused by bleeding under the skin]), and orbital ecchymosis (bruising around the eyes, characterized by dark blue or purple discoloration on the upper and lower eyelids). The Radiology Report indicated an impression of mild left frontal hematoma. During a review of Resident 1's GACH Radiology Report, dated 3/30/2026 at 4:35 p.m., the Radiology Report indicated a CT maxillofacial structures (refer to the bones, soft tissues, muscles, nerves, and blood vessels [a network of tube-like channels that transport blood throughout the body] that make up the mouth, jaws, face, and neck) without contrast was performed because of fall, nasal contusion, and orbital ecchymosis. The Radiology Report indicated impressions of minimally depressed fracture of the nasal bones and bony nasal septum (thin wall that divides two structures) and mild left frontal scalp hematoma. During a review of Resident 1's GACH Emergency Department Report, dated 3/30/2026 at 9:38 p.m., the Report indicated Resident 1's final impression was nasal fracture and additional impressions included blunt head trauma and forehead hematoma. During a review of Resident 1's Skin Assessment, dated 3/31/2026 timed at 3:45 p.m., the Skin Assessment indicated Resident 1 was readmitted back to the facility following an emergency room (ER) visit related to a fall where Resident 1 sustained nasal fracture and bruising of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the peri-orbital (around the eye) and nose. During an interview with Resident 1 and Resident 1's Family Member (FM) 1 in the activity room on 4/10/2026 at 2:30 p.m., Resident 1 stated she (Resident 1) fell down last week (unable to indicate date and time). FM 1 stated she requested the facility (unable to recall the date and name of the staff) to provide Resident 1 with a walker for ambulation because Resident 1 had fallen twice in the facility. FM 1 stated that as a result of not providing Resident 1 with a walker, Resident 1 fell on 3/30/26 and suffered a nose fracture. During an interview on 4/9/2026 at 11:15 a.m., Certified Nurse Assistant (CNA) 1 stated that Resident 1 had unsteady gait and had been walking without an FWW. CNA 1 stated she did not know that Resident 1 needed to use a FWW when walking. During an interview on 4/9/2026 at 12 p.m., LVN 1 stated that Resident 1 had unsteady gait and always walked in the hallway without using an FWW. LVN 1 stated that he (LVN 1) was not aware that PT recommended for Resident 1 to use FWW when ambulating. LVN 1 stated that on 3/30/2026, at approximately 1:45 p.m., he (LVN 1) was in the Nursing Station, and he heard someone (name not indicated) yelling help. LVN 1 stated he went to the hallway and witnessed Resident 1 lying on the floor with minimal blood noted on the nose. LVN 1 further stated that Resident 1 sustained a nose injury. LVN 1 stated Resident 1 was subsequently transferred to GACH 1 on 3/30/2026 at 2:40 p.m. for further evaluation and treatment. LVN 1 stated Resident 1's laceration measured two cm in length, one cm in width, and 0.2 cm in depth and the forehead hematoma measured three cm in length and 3 cm in width. LVN 1 stated he (LVN 1) applied a dressing on Resident 1's laceration to control the bleeding. During an interview on 4/10/2025 at 10 a.m. with Registered Nurse (RN) 1, RN 1 stated and confirmed that on 3/30/2026, at approximately 1:45 p.m., she (RN 1) was informed by a facility staff (unable to recall who) that Resident 1 sustained a fall. RN 1 stated that upon entering the hallway she witnessed Resident 1 on the floor, and that Resident 1 had moderate bleeding on the nose. RN 1 stated that the purpose of the FWW is to assist residents with ambulation and to prevent falls. RN 1 stated that facility staff failed to obtain a physician's order for FWW for Resident 1 per PT recommendation. RN 1 stated that failure to obtain a physician's order for the FWW had the potential for Resident 1 to suffer repeated falls and sustain more serious injuries, hospitalization, and even death. RN 1 stated that on 3/30/2025, Resident 1 fell and suffered a posterior scalp laceration and hematoma, and a nose fracture could have been prevented if Resident 1 was provided with FWW as recommended by the Rehabilitation Department which could have potentially prevented Resident 1's fall that resulted to injury. During a telephone interview with Resident 1's MD 1 on 4/10/2026, at 12 p.m., MD 1 stated that the facility staff did not inform (him) MD 1 that the PT recommended that Resident 1 use a FWW when ambulating. MD 1 stated he (MD 1) would have ordered FWW for Resident 1. MD 1 stated that repeated falls can lead to severe injuries like head bleed and even death. During an interview on 4/10/2026 at 3 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was not added to the Falling Star Program after Resident 1's falls on 2/4/2026 and 2/8/2026. The DON stated that the purpose of the Falling Star Program was to alert and inform facility staff of residents identified as high risk for falls. The DON further stated that the Falling Star Fall Prevention Program should have been initiated for Resident 1 on 2/4/2026, when Resident 1 was assessed and identified as being at high risk for falls. The DON stated that the facility's Falling Star Program serves as a communication tool to enhance staff awareness of residents identified as being at risk for falls. The DON stated that the goal of the Falling Star Program is to implement close supervision interventions including increased monitoring such as hourly rounding, particularly for residents placed in the Red Star category, indicating resident had two or more falls within a one-month period. The DON further stated that the Falling Star Program should have been initiated for Resident 1 on 2/4/2026, following completion of a fall risk assessment that identified Resident 1 as being at high risk for falls. The DON stated Resident 1 sustained multiple falls on 2/4/2026, 2/8/2026, and 3/30/26. The DON stated that the facility staff did not inform her of the specific details regarding Resident 1's fall on 3/30/2026 at 1:45 p.m. The DON stated she (DON) did not receive any communication from PT regarding Resident 1's use of FWW for ambulation and further (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated that in the future there needs to be better communication between staff from PT to nursing staff (CNAs, LVNs, and RNs) and to discuss during huddles to make sure everyone is on the same page. The DON stated that facility staff failed to provide Resident 1 with a front wheel walker as suggested by the Rehabilitation Department. The DON stated that Resident 1 was only added to the facility's Falling Star Program on 3/31/2026 (nearly one month after Resident 1's initial fall on 2/4/2026). The DON stated there was no documented evidence that facility staff provided Resident 1 with supervision and hourly monitoring on 2/4/2026 and 2/8/2026 when Resident 1 fell as indicated in the facility's Falling Star Program. During a review of the facility-provided P&P titled, Falling Star Program, last reviewed on 7/2025, the P&P indicated, Residents identified at risk for falls will participate in the falling star program. Procedure: 1. Residents will be assessed for fall risk, utilizing the Fall Risk Assessment form and appropriate interventions will be provided, including . Care Plan: Falling Star or Super Star. 2. An identifying colorful Star will be placed in personal resident areas; e.g., head of bed, on name plate of entrance to room, bathroom door, identifying the bed number of resident, on the inside and outside of the door, closet door, wheelchair . - on back of chair. During a review of the facility provided P&P titled, Safety and Supervision of Residents, last reviewed on 7/2025, the P&P indicated, Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Individualized, Resident-Centered Approach to Safety: 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks . including adequate supervision and assistive devices. 4. Implementing interventions to reduce to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; . d. Ensuring that interventions are implemented. 5. Monitoring the effectiveness of interventions shall including the following: a. Ensuring that interventions are implemented correctly and consistently; b. Evaluating the effectiveness of interventions as needed; and d. Evaluating the effectiveness of new or revised interventions. Systems Approach to Safety. 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. During review of the facility-provided P&P titled, Care Plans, Comprehensive Person Centered, last reviewed on 7/2025, 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. Policy Interpretation and Implementation. 1. The interdisciplinary team (IDT - collaboration where healthcare professionals from different disciplines work together to plan and coordinate resident care), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.During a review of the facility-provided P&P titled, Fall Risk Assessment, last reviewed on 7/2025, the P&P indicated, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information. 9. The staff and attending physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences of risk factors that are not modifiable.