

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Imperial Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of six sampled residents' (Resident 4, Resident 5, and Resident 6) meal trays were served at the same time. These deficient practices resulted in Resident 4 and Resident 6's agitation. This deficient practice furthermore had the potential to negatively affect Resident 4's, Resident 5's, and Resident 6's dignity and self-esteem. Findings: a. During a review of Resident 4's undated admission Record, the admission Record indicated the facility admitted Resident 4 on 7/3/2026 with diagnoses including metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), restlessness and agitation, and unspecified dementia (a decline in brain function including memory, language, reasoning, and behavior severe enough to interfere with daily life but the specific type had not been identified). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 7/6/2026, the MDS indicated Resident 4's cognitive (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) skills for daily decision making were severely impaired. The MDS indicated Resident 4 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating. During a review of Resident 4's Order Summary Report (OSR), for the active orders as of 7/20/2026, the OSR indicated a physician order for Resident 4's diet with an order date of 7/6/2026. The OSR indicated Resident 1 was on a regular diet with soft and bite-sized texture. During a concurrent observation and interview on 7/20/2026 at 12:13 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated Resident 4 was not served lunch while the other residents, sitting at the same table, were already eating. Resident 4 was visibly agitated and yelled asking for food. Resident 4 went out of the dining room looking for the meal tray. The IPN stated failure to provide meals at the same time to the residents sitting at the same table could negatively affect the residents' dignity. During an observation on 7/20/2026 at 12:24 p.m., Resident 4 was observed being wheeled back inside the dining room. Resident 4 was served the lunch meal 11 minutes after the other residents had started eating their meal, sitting at the same table. b. During a review of Resident 5's undated admission Record, the admission Record indicated the facility admitted Resident 5 on 6/12/2024 with diagnoses including unspecified dementia, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental health condition that involve excessive fear, worry, or nervousness that interfere with daily life). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 5 required set up or clean-up assistance (helper assists only prior to or following the activity) with eating. During a review of Resident 5's OSR, for the active orders as of 7/20/2026, the OSR indicated a physician order for Resident 5's diet with an order date (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of 3/19/2026. The OSR indicated Resident 5 was on a regular texture diet and with no added salt. During a concurrent observation and interview on 7/20/2026 at 12:13 p.m. with the IPN, the IPN stated Resident 5 was not served the lunch meal tray while the other residents, sitting at the same table, were already eating. Resident 5 was observed with head down staring at the table. The resident in front of Resident 5 was observed asking the facility staff where Resident 5's food was. The IPN stated failure to provide meals at the same time to the residents sitting at the same table could negatively affect the residents' dignity. During an observation on 7/20/2026 at 12:22 p.m., Resident 5 received the lunch meal tray, nine minutes after the other residents had started eating their meal, sitting at the same table. c. During a review of Resident 6's undated admission Record, the admission Record indicated the facility admitted Resident 6 on 7/3/2026 with diagnoses including metabolic encephalopathy, unspecified dementia, and type 2 diabetes mellitus (a disease that occurs when the blood sugar level is too high). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 6 required moderate assistance with eating. During a review of Resident 6's OSR, for the active orders as of 7/21/2026, the OSR indicated a physician order for Resident 6's diet with an order date of 7/14/2026. The OSR indicated Resident 6 was on a puree texture diet with no added salt. During a concurrent observation and interview on 7/20/2026 at 12:13 p.m. with the IPN, the IPN stated Resident 6 was not served the lunch meal tray while the other residents, sitting at the same table, were already eating. The IPN stated Resident 6 was visibly agitated, yelling, and pointing at the table. Resident was observed looking at other residents' food, sitting in the table. The IPN stated failure to provide the meals at the same time to the residents sitting at he same table could negatively affect the residents' dignity. During an observation on 7/20/2026 at 12:23 p.m., Resident 6 received the lunch meal tray, nine minutes after the other residents had started eating their meal, sitting at the same table. During an interview on 7/21/2026 at 11:05 a.m. with the Director of Nursing (DON), the DON stated the licensed nurses should ensure the residents' meal trays are provided to the residents at the same table at the same time. The DON stated the residents could feel left out, started grabbing other resident food, and could cause increased anxiety. The DON stated the residents with existing diagnosis of depression could potentially exacerbate. The DON acknowledged and stated the facility failed to ensure the residents seated at the same table were served at the same time to maintain residents' dignity. During a review of the facility's policy and procedure (PnP) titled, Resident Rights, last reviewed on 7/2026, the PnP indicated employees shall treat all residents with kindness, respect, and dignity. The PnP indicated these rights include the resident's right to: a. a dignified existence. b. be treated with respect, kindness, and dignity. During a review of the facility's PnP titled, Dignity, last reviewed on 7/2026, the PnP indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The PnP indicated Residents are treated with dignity and respect at all times. The PnP indicated when assisting with care, residents are supported in exercising their rights.residents are .provided with a dignified dining experience.		