

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 06/20/2025
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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) within reach of the resident for one of one sampled resident (Resident 5) reviewed under accommodation.</p> <p>This deficient practice had the potential for residents unable to summon health care worker for help as needed.</p> <p>Findings:</p> <p>During a review of Resident 5's admission Record, the admission Record indicated the facility originally admitted the resident on 3/23/2024 and readmitted the resident on 4/3/2025 with diagnoses including muscle weakness, abnormalities of gait (a manner of walking or moving on foot) and mobility, and history of falling.</p> <p>During a review of Resident 5's History and Physical (H&P), dated 4/4/2025, the H&P indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated the resident usually had the ability to make self-understood and understand others, and had impaired vision. The MDS indicated the resident had moderate cognitive impairment (someone's thinking, memory, and judgment have noticeably declined, impacting their ability to handle daily tasks and responsibilities, but they can still manage some basic activities independently) and required substantial to setup assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 5's Fall Risk Assessment, dated 4/24/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 5's Care Plan (CP) Report titled, Resident is at risk for falls/injury, last revised on 4/6/2025, the CP indicated an intervention to keep call light within easy reach and encourage resident to use it to get assistance.</p> <p>(continued on next page)</p>

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: 555707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2025
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 6/16/2025 at 9:17 a.m. with the Infection Preventionist (IP) inside Resident 5's room, Resident 5's call light was on the floor at the left side of the bed. The IP stated Resident 5's call light should not be on the floor and the call light should be within reach for the resident to call when she needed to get out of bed or for any other assistance. The IP stated it was the responsibility of all staff when they round on their residents to ensure the residents are safe such as making sure the call light is within reach.</p> <p>During an interview on 6/20/2025 at 11:57 a.m. with the Director of Nursing (DON), the DON stated Resident 5's call light should be within reach at all times so they can call when they need help. The DON stated some residents are hard to ensure the call light is within reach especially when they are confused. The DON stated for these types of residents they should round at least every hour to ensure that the call light is within reach. The DON stated if the resident desires to not have the call light within reach and they are cognitively intact, they will respect the right of the resident, and it will be care planned.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled, Call System, Resident, last reviewed on 7/2024, the P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.</p>		

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 06/20/2025
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)		
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the results of the most recent survey was posted in a place readily accessible where individuals including the residents wishing to examine the survey results do not have to ask the assistance of the staff to see them for one of eight sampled residents (Resident 74) reviewed during Resident Council facility task.</p> <p>This deficient practice had the potential for the residents and their legal representatives to not be fully informed of the facility's deficient practices and how they were corrected.</p> <p>Findings:</p> <p>During a review of Resident 74's admission Record, the admission Record indicated the facility admitted the resident on 6/22/2021, and readmitted the resident on 10/25/2024, with diagnoses including depression (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest), anxiety disorder (persistent and excessive worry that interferes with daily activities), and schizophrenia (a mental illness that is characterized by disturbances in thought).</p> <p>During a review of Resident 74's History and Physical (H&P), dated 10/27/2024, the H&P indicated the resident was unable to make decisions.</p> <p>During a review of Resident 74's Minimum Data Set (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (means a person has normal or healthy thinking abilities).</p> <p>During an interview on 6/17/2025 at 2:40 p.m. with Resident 74 (Resident Council President), while conducting the Resident Council Meeting facility task, Resident 74 stated she knows where to find the survey binder containing last year's survey results, however, it is kept on the opposite side of the locked gate near the Administrator's Office and is not readily available for residents to access them. The other seven (7) attendees of the Resident council meeting confirmed Resident 74's observation and statement.</p> <p>During an observation on 6/17/2025 at 3:05 p.m., the binder holder near the Administrator's Office behind a locked gate did not contain a binder.</p> <p>During a concurrent observation and interview on 6/17/2025 at 3:07 p.m. with the Business Office Assistant (BOA), the BOA carried the survey binder and stated she was bringing the survey binder to the DON's office. The BOA stated the binder is kept on the opposite side of the locked gate near the Administrator's Office.</p> <p>During an interview on 6/17/2025 at 3:20 p.m. with the Director of Nursing (DON), the DON stated the survey binder is located near the Administrator's Office on the opposite side of a locked gate. The DON stated the location of the survey binder is where it is visible and accessible to family. The DON stated for residents to access them they will have to ask a staff to get them for them. The DON stated, per her knowledge, the survey binder needs to be in one designated place.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)
<p>F 0577</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/20/2025 at 11:57 a.m. with the DON, the DON stated the survey binder is located at the opposite side of the locked gate near the Administrator's Office and is readily accessible to visitors and families, however, for residents it is not accessible as they need to ask the assistance of the staff to get them.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled, Resident Rights, last reviewed on 7/2024, the P&P indicated employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:</p> <p>w. examine survey results.</p> <p>During a review of the facility's recent P&P titled Examination of Survey Results, last reviewed on 7/2024, the P&P indicated survey reports and plans of correction are readily accessible to the resident, family members, resident representatives and to the public. A copy of the most recent survey report and any plans of correction are kept in a binder in the residents' day room.</p>

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 06/20/2025
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for three of three sampled residents (Residents 70, 81, and 102) reviewed for physical restraints by failing to ensure:</p> <ol style="list-style-type: none"> Resident 70's restraint bed placed against the wall had a physician's order, informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the resident and/or representative, and a physical restraint assessment for its safe use. Residents 81 and 102's restraint pad/tab alarm (a device that alerts staff when a resident who is at risk for falls is attempting to get up from their bed or chair) had a physician's order, informed consent, and had a physical restraint assessment prior to its use. <p>These deficient practices had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (an occurrence involving a patient who is caught, trapped, or entangled in a hospital bed system), and death of residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 70's admission Record, the admission Record indicated the facility admitted the resident on 10/31/2023, and readmitted the resident on 6/13/2025, with diagnoses including abnormalities of gait (a manner of walking or moving on foot) and mobility, muscle weakness, and history of falling. <p>During a review of Resident 70's History and Physical (H&P), dated 6/17/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 70's Minimum data Set (MDS - a resident assessment tool), dated 5/13/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated the resident required partial to set up assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a fall with injury.</p> <p>During a review of Resident 70's Order Summary Report, dated 6/20/2025, the Order Summary Report did not indicate an order for restraint bed placed against the wall.</p> <p>During a review of Resident 70's Fall Risk Assessment, dated 6/14/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 70's Care Plan (CP) Report titled, Falling Star Program at risk for falls, initiated on 6/14/2025, the CP indicated an intervention to respect resident wishes for independence and dignity and restraint assessment.</p> <p>During a concurrent observation and interview on 6/16/2025 at 11:05 a.m. with Treatment Nurse (TN) 1 inside Resident 70's room, observed Resident 70's bed was placed against the wall at the right side of the bed. TN 1 stated placing the bed against the wall is a restraint because it limits the residents bed exit and entry to one side of the bed. TN 1 stated before applying a restraint on a resident they should obtain a physician's order, informed consent from the resident or representative, restraint assessment, and a care plan on its use. TN 1 stated obtaining all the necessary order, consents, assessments, and care plan before applying the restraint ensures its safe use.</p> <p>During a concurrent interview and record review on 6/18/2025 at 9:43 a.m. with the Assistant Director of Nursing (ADON), Resident 70's Order Summary Report, Informed Consents, Restraint Assessment, and Care Plans were reviewed. The ADON stated there was no physician's order, no informed consent obtained from the resident or representative, no restraint assessment, and no care plan developed and implemented on the use of bed placed against the wall on the resident. The ADON stated prior to applying restraints on resident they need to obtain a physician's order, informed consent from the resident or representative to honor their right to agree or disagree with the proposed treatment, a restraint assessment to prevent bed entrapment, and a care plan to standardize the care provided to the resident.</p> <p>During an interview on 6/20/2025 at 11:57 a.m. with the Director of Nursing (DON), the DON stated the staff should have obtained a physician's order, obtained an informed consent from the resident or representative after explaining the risk and benefits of applying the restraint, performed a restraint assessment to prevent bed entrapment, and developed a care plan on its use to ensure Resident 70's safety.</p> <p>2. During a review of Resident 81's admission Record, the admission Record indicated the facility admitted the resident on 2/18/2025, with diagnoses including traumatic subdural hemorrhage (is essentially bleeding on the surface of the brain, under the skull's tough outer layer (dura mater), caused by a head injury), lack of coordination, and muscle weakness.</p> <p>During a review of Resident 81's H&P, dated 2/19/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 81's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition. The MDS indicated the resident was dependent to needing substantial assistance on mobility and ADLs.</p> <p>During a review of Resident 81's Order Summary Report, dated 6/20/2025, the Order Summary Report did not indicate an order for pad/tab alarm.</p> <p>During a review of Resident 81's Fall Risk Assessment, dated 5/27/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 81's Care Plan (CP) Report titled Resident is at risk for falls/injury, last revised on 2/18/2025, the CP indicated to visibly observed resident frequently.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/16/2025 at 10:06 a.m. with Restorative Nursing Assistant (RNA) 2 inside Resident 81's room, Resident 81 had a tab/pad alarm on the bed. RNA 2 stated the pad/tab alarm was placed on Resident 81's bed to alert the staff when the resident is getting out of bed. RNA 2 stated the resident was high risk for falls that is why they applied the pad/tab alarm on the resident.</p> <p>During a concurrent interview and record review on 6/18/2025 at 10:06 a.m. with Registered Nurse (RN) 1, Resident 81's Order Summary Report, Informed Consents, Restraint Assessment, and Care Plans were reviewed. RN 1 stated there was no order for pad/tab alarms on the resident, no informed consent obtained, no restraint assessment, and no care plan prior to application of the restraint. RN 1 stated the pad/tab alarm is a restraint and requires an order, assessment, consent, and a care plan to ensure its safe use.</p> <p>During an interview on 6/20/2025 at 11:57 a.m. with the DON, the DON stated pad/tab alarms are restraints. The DON stated the staff should have obtained a physician's order, informed consent from the resident or representative, performed a restraint assessment, and developed a care plan on its use prior to application on Resident 81. The DON stated the pad/tab alarms limits the movement of the resident by sounding alarms every time they get out of bed. The excessive use of pad/tab alarms can result to deconditioning on residents.</p> <p>3. During a review of Resident 102's admission Record, the admission Record indicated the facility admitted the resident on 1/10/2024, with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), age-related osteoporosis (is a condition where your bones become weak and fragile as you get older), and stress fracture (a tiny crack in a bone caused by repetitive stress, often from overuse in activities like running or jumping) of the pelvis.</p> <p>During a review of Resident 102's H&P, dated 1/28/2025, the H&P indicated the resident was alert and oriented to person only, and had minimal vocalization.</p> <p>During a review of Resident 102's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (means a person has significant problems with their thinking, remembering, and learning abilities, to the point that it severely affects their daily life and ability to live independently). The MDS indicated the resident was dependent to requiring substantial assistance on mobility and ADLs.</p> <p>During a review of Resident 102's Order Summary Report, dated 6/20/2025, the Order Summary Report did not indicate an order for pad/tab alarm.</p> <p>During a review of Resident 102's Fall Risk Assessment, dated 4/15/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 102's Care Plan (CP) Report titled Resident is on low bed with floor mat (a cushioned pad placed on the floor next to a bed to help prevent or lessen injuries from falls) to decrease potential injury, last revised on 5/5/2025, the CP indicated an intervention to attempt to use less restrictive devices on an ongoing basis.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/16/2025 at 10:06 a.m. with RNA 2 inside Resident 102's room, Resident 102 had a pad/tab alarm applied on the bed. RNA 2 stated the resident had the pad/tab alarm on to alert the staff when the resident is trying to get out of the bed to prevent a fall.</p> <p>During a concurrent interview and record review on 6/20/2025 at 9:17 a.m. with Licensed Vocational Nurse (LVN) 7, Resident 102's Order Summary Report, Informed Consents, Restraint Assessment, and Care Plans were reviewed. LVN 2 stated there was no physician's order, no informed consent from the resident or representative, no restraint assessment, and no care plan was developed on the use of pad/tab alarm on the resident. LVN 2 stated it was important to have all the components mentioned to ensure the application of the restraint is safe and to honor the resident's right to informed consent.</p> <p>During an interview on 6/20/2025 at 11:57 a.m. with the DON, the DON stated pad/tab alarms are restraints. The DON stated the staff should have obtained a physician's order, informed consent from the resident or representative, performed a restraint assessment, and developed a care plan on its use prior to application on Resident 102. The DON stated the pad/tab alarms limits the movement of the resident by sounding alarms every time they get out of bed. The excessive use of pad/tab alarms can result in deconditioning of residents.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled, Use of Restraints, last reviewed on 7/2024, the P&P indicated physical restraints are defined as any manual method of physical or mechanical, device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restrict normal access to one's body. Prior to placing a resident in restraints, there shall be an assessment and a review to determine the need for restraints. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following:</p> <ol style="list-style-type: none"> a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint, <p>Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use, seven days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.</p> <p>During a review of the facility's recent P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 7/2024, 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. The comprehensive, person-centered care plan is developed within seven days.</p>		

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 06/20/2025
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)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Residents 116) was free from chemical restraints (use of medication to manage a resident's behavior or restrict their freedom of movement, primarily to control agitation [a feeling of irritability, mental distress or severe restlessness] or aggression [any behavior, word, or action that is intended to harm another person, animal, or object]) by failing to ensure quarterly (every three months) behavior management interdisciplinary team (IDT - a coordinated group of experts from several different fields who work together) meeting for Resident 116 use of psychotropic (medications that affect the mind, emotions, and behavior) medication was done.</p> <p>This failure had the potential to result in unnecessary chemical restraint and placed Residents 116 at risk for decline, isolation (a state of reduced social interaction and lack of meaningful connections with others) and injury.</p> <p>Findings:</p> <p>During a record review of Resident 116's admission Record, the admission Record indicated the facility admitted Resident 116 on 10/15/2024 with diagnoses including unspecified (unconfirmed) cerebrovascular disease (a group of conditions that affect blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia (reduced blood flow to the brain, which damages brain tissue and impairs cognitive functions).</p> <p>During a review of Resident 116's History and Physical Examination (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) Visit, dated 10/15/2024, the H&P Visit indicated Resident 116 was alert and needed visual cues (non-verbal signals that provide information, guide actions, or enhance understanding through visual elements).</p> <p>During a review of Resident 116's Minimum Data Set (MDS - a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 116's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 116 was on antidepressant (medication used to treat depression and other mental health condition) medication.</p> <p>During a review of Resident 116's Physician Order, dated 10/16/2024, the Physician Order indicated the following:</p> <ol style="list-style-type: none"> 1. Mirtazapine (antidepressant medication used to treat depression) oral tablet 15 milligram (mg - metric unit of measurement, used for medication dosage and/or amount), give 15 mg by mouth at bedtime for depression as manifested by extreme sadness causing social isolation. 2. Sertraline hydrochloride (medication used to treat depression) oral tablet 50 mg, give 50 mg by mouth daily for depression manifested by inability to cope with daily living activities causing stress. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/18/2025 at 10:16 a.m. with the Assistant Director of Nursing (ADON), Resident 116's IDT-Behavior Management / Psychotropic Regimen Review (Behavioral IDT - a group of professionals from different disciplines collaborating to provide comprehensive care for residents with mental health and substance use challenges), dated 10/16/2024, was reviewed. The ADON stated Resident 116 was on sertraline and mirtazapine. The ADON stated the last behavioral IDT was done on 10/16/2024 and no other behavioral IDT followed. The ADON stated behavioral IDT should be done quarterly with the Attending Physician or Psychiatrist (a medical doctor who specializes in the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) to determine if Resident 116's sertraline and mirtazapine needed to be continued or discontinued. The ADON stated the importance of behavioral IDT was to speak to the physician regarding Resident 116 behavior.</p> <p>During an interview on 6/20/2025 at 9:37 a.m. with Registered Nurse (RN) 1, RN 1 stated the ADON was assigned to discuss Resident 116's behavior with the physician and to complete the behavioral IDT. RN 1 stated every three months, an IDT assessment is done for Resident 116's use of psychotropic medications. RN 1 stated if there is no documented behavioral IDT in Resident 116's medical record, it means it was not done. RN 1 stated in a behavioral IDT, RN 1, the ADON, physician, and pharmacy review all medications to discuss if medication needed to be continued or to decrease the dosage. RN 1 stated no quarterly behavioral IDT meant Resident 116's behavior was not assessed, and medication was not discussed if to continue or not.</p> <p>During an interview on 6/20/2025 at 11:06 a.m. with the Administrator (ADM), the ADM stated the facility does not have a policy for chemical restraint but follows the Psychotherapeutic Medication (also known as psychotropic drugs, medications that affect the mind, brain, and behavior) policy and procedure (P&P).</p> <p>During a concurrent interview and record review on 6/20/2025 at 12:34 p.m. with the Director of Nursing (DON), the facility's P&P titled, Psychotherapeutic Medications, undated and last reviewed on 7/2024, was reviewed and the P&P indicated, Evaluate the resident's response to psychotropic medication therapy (antianxiety [medications used to treat the symptoms of anxiety, such as fear, dread, uneasiness, and muscle tightness], antidepressant, hypnotic [also known as sleeping pills are designed specifically to help you fall asleep and stay asleep] and antipsychotic) to determine that the medications are appropriate and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences (undesirable consequence or negative outcome) related to medication therapy The facility will communicate with the physician/psychiatrist and adjust the medication as ordered. The DON stated behavioral IDT is done for residents on psychotropic medication initially, quarterly, annually and as needed. The DON stated the facility failed to conduct Resident 116's behavioral IDT quarterly. The DON stated the facility needs the IDT to assess Resident 116 and follow up with the physician to identify if current psychotropic medications are still needed or not, so medication could be discontinued or gradually decreased. The DON stated Resident 116 could potentially be taking unnecessary medication.</p> <p>During a review of facility's P&P titled, Antipsychotic Medication Use, dated 2001 and last reviewed on 7/2024, the P&P indicated, The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12. Antipsychotic medications will not be used if the only symptoms are one or more of the following:</p> <ul style="list-style-type: none"> a. Wandering (moving or traveling from place to place without a specific destination or plan); b. Poor self-care; c. Restlessness; d. Impaired memory; e. Mild anxiety; f. Insomnia (trouble falling asleep or staying asleep); g. Inattention or indifference to surroundings; h. Sadness or crying alone that is not related to depression or other psychiatric disorders; i. Fidgeting (making small movements with your body, usually your hands and feet); j. Nervousness; or k. Uncooperativeness <p>17. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications.</p> <p>During a review of facility's P&P titled, IDT Conference, undated and last reviewed on 7/2024, the P&P indicated, The Director of Nursing, Social Service Designee, or any other designated person, shall contact all professionals involved in caring for the selected residents, and shall request that each be present when the resident's care plan is reviewed. The resident and/or resident responsible party will be invited to the IDT meeting, and the facility will document the reason if resident/responsible party could not to the participate IDT in meeting.</p> <p>The content of the IDT will include but are not limited to:</p> <ul style="list-style-type: none"> a. The date the plan was reviewed. b. Reason of the IDT. c. Areas reviewed (the areas may include), . <p>13. Psychotropic medications.</p> <p>(continued on next page)</p>		

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 06/20/2025
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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's P&P titled, Use of Restraints, dated 3/2023 and last reviewed on 7/2024, the P&P indicated, Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination.		

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 06/20/2025
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of resident to resident abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) immediately, but no later than two hours after the allegation was made to the State Survey Agency (CDPH, California Department of Public Health), the Ombudsman (a resident advocate), and local law enforcement (LLE) in accordance with federal and state law for one of seven sampled residents (Resident 37) reviewed under the Hospitalization care area.</p> <p>This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from harm from abuse.</p> <p>Findings:</p> <p>a. During a review of Resident 57's admission Record (AR), the AR indicated the facility originally admitted the resident on 7/8/2024 and most recently admitted the resident on 5/13/2025 with diagnoses including encephalopathy (a change in your brain function due to injury or disease), unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and insomnia (difficulty sleeping).</p> <p>During a review of Resident 57's Minimum Data Set (MDS - resident assessment tool), dated 5/30/2025, the MDS indicated the resident was sometimes able to understand others and was sometimes able to make themselves understood. The MDS further indicated that the resident required substantial/maximal assistance from staff for lower body dressing, toileting, personal hygiene, and bathing.</p> <p>b. During a review of Resident 37's AR, the AR indicated the facility originally admitted the resident on 1/2/2024 with diagnoses including unspecified dementia, carcinoma (cancer - a disease where some of the body's cells grow out of control and can spread to other parts of the body) of left bronchus (airway that leads from the trachea [windpipe] to a lung) and lung, and restlessness and agitation.</p> <p>During a review of Resident 37's MDS, dated [DATE], the MDS indicated the resident was sometimes able to understand others and was sometimes able to make themselves understood. The MDS further indicated that the resident required partial / moderate assistance from staff for upper body dressing, toileting, and personal hygiene; and the resident required staff supervision for mobility.</p> <p>During a review of Resident 37's History and Physical (H&P), dated 1/4/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 37's Physician Orders, dated 6/16/2025, at 7:56 a.m., the Physician's Order indicated to transfer the resident via 911 to General Acute Care Hospital (GACH) 1.</p> <p>(continued on next page)</p>

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 06/20/2025
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 37's Change of Condition (COC) Interact Assessment Form, dated 6/16/2025, at 7:55 a.m., the COC Interact Assessment Form indicated Resident 33 was found on the floor at 6:30 a.m. just outside the bathroom in the resident's room, the resident was on their right side pointing to the hip and crying out that it hurts so bad. The COC Interact Assessment Form indicated emergency services were called and the resident was transported to GACH 1. The COC Interact Assessment Form indicated it was completed by Registered Nurse (RN) 7.</p> <p>During a review of the facility provided Fax Confirmation Sheet with Letter, dated 6/17/2025, at 10:57 a.m., the Fax Confirmation Sheet indicated a fax was sent on 6/17/2025, at 10:57 a.m., that included a letter to the Department of Public Health (CDPH, the State Survey Agency) indicating notification that Resident 33 had sustained a fall, was transferred to the hospital, and it was reported that the resident sustained a comminuted (broken into pieces) mildly displaced (moved a little bit out of the normal position) impacted (jammed together) intertrochanteric (upper part of the thigh bone) fracture (broken bone) of the right hip.</p> <p>During a review of Resident 37's Care Plan titled, Resident and / or responsible party have been made aware that the facility has stable systems to prevent not only abuse, but also those practices and omissions, neglect and misappropriation of property that if left unchecked, lead to abuse, initiated 3/19/2024, the CP indicated an intervention to inform the resident that they may report abuse.</p> <p>During an interview on 6/18/2025 at 6:21 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated on 6/16/2025 at approximately 6:20 a.m., LVN 2 was called to Resident 33's room. LVN 2 stated LVN 2 found Resident 33 on the floor near the restroom. LVN 2 stated Resident 57 was standing over Resident 33 when Resident 33 stated multiple times, he pushed me. LVN 2 stated RN 7 came to assess Resident 33 and emergency services were called to take Resident 33 to the hospital. LVN 2 stated LVN 2 spoke with the Director of Nursing (DON) on 6/17/2025 regarding the incident.</p> <p>During a concurrent interview and record review on 6/18/2025 at 8:41 a.m. with the DON, the Fax Confirmation Sheet with Letter, dated 6/17/2025, at 10:57 a.m., was reviewed. The DON stated the facility policy and procedure (P&P) is to report all allegations of abuse to CDPH, the ombudsman, and the police within two hours of learning of the allegation. The DON stated the facility process is for any staff member that is made aware of an allegation of abuse to report the allegation to their supervisor and the Administrator (ADM). The DON stated the ADM is the abuse coordinator and reports all allegations to CDPH, the ombudsman, and the police within two hours. The DON stated it was important to report all allegations of abuse within two hours to proceed with the investigation to determine if abuse occurred and to ensure resident safety. The DON stated on 6/17/2025, after reporting Resident 33's injury to CDPH, LVN 2 informed the DON that Resident 33 made an allegation of abuse that Resident 57 pushed Resident 33. The DON stated LVN 2 did not inform the DON or Administrator of Resident 33's allegation of abuse when it occurred on 6/16/2025, but LVN 2 should have. The DON stated Resident 33's allegation of abuse was not reported to CDPH, the police, or the ombudsman because the DON and ADM were not aware of the allegation. The DON stated on 6/17/2025 when LVN 2 notified the DON of Resident 33's allegation of abuse, the DON also did not report the allegation to CDPH, the police, or the ombudsman. The DON stated looking back, the DON also should have reported the allegation on 6/17/2025 and did not.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/20/2025 at 12:48 p.m. with the ADM, the ADM stated on 6/17/2025 the ADM was made aware that on 6/16/2025, at approximately 6:30 a.m., Resident 33 alleged that Resident 57 pushed Resident 33. The ADM stated Resident 33's allegation was an allegation of abuse. The ADM stated LVN 2 and RN 7 had a responsibility to ensure the allegation of abuse was reported within two hours, but LVN 2 and RN 7 did not. The ADM stated on 6/17/2025, the ADM had already reported Resident 33's injury to CDPH and the ADM did not think to also report the allegation of abuse. The ADM stated looking back, the facility should have reported the allegation of abuse and called the police, but they did not. The ADM stated it was an error on their part. The ADM stated when Resident 33's allegation of abuse was not reported until two days after the allegation was made, there was a potential for a delay in investigating to ensure abuse was stopped and residents were safe. The ADM stated the facility P&P was not followed.</p> <p>During an interview on 6/20/2025 at 1:35 p.m. with LVN 2, LVN 2 stated on 6/16/2025 Resident 33 alleged Resident 57 hurt Resident 33. LVN 2 stated RN 7 was also aware of Resident 33's allegation. LVN 2 stated LVN 2 thought RN 7 would report the allegation, but LVN 2 did not follow up with RN 7.</p> <p>During an interview on 6/20/2025 at 2:30 p.m. with the DON, the DON stated the DON spoke with RN 7 and RN 7 did not report Resident 33's allegation of abuse to anyone on 6/16/2025. The DON stated RN 7 did not give a reason for not reporting Resident 33's allegation of abuse. The DON stated the facility P&P was not followed.</p> <p>During a review of the facility provided P&P titled, Accidents and Incidents - Investigating and Reporting, last reviewed 7/2024, the P&P indicated all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The following data, as applicable, shall be included on the Report of Incident/Accident form:</p> <ul style="list-style-type: none"> a) The date and time the accident or incident took place; b) The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c) The circumstances surrounding the accident or incident; d) Where the accident or incident took place; e) The name(s) of witnesses and their accounts of the accident or incident; f) The injured person's account of the accident or incident. <p>During a review of the facility provided P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, last reviewed 7/2024, the P&P indicated all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Reporting Allegations to the Administrator and Authorities</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</p> <p>2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:</p> <ul style="list-style-type: none"> a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. <p>3. Immediately is defined as:</p> <ul style="list-style-type: none"> a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. <p>4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone.</p> <p>5. Notices include, as appropriate:</p> <ul style="list-style-type: none"> a. the resident's name; b. the resident's room number; c. the type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.); d. the date and time the alleged incident occurred; e. the name(s) of all persons involved in the alleged incident; and f. what immediate action was taken by the facility. <p>6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.</p>		

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 06/20/2025
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)		
<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete and transmit the Minimum Data Set (MDS - a resident assessment tool) timely for six of six sampled residents (Resident 107, 110, 113, 85, 75, and 74) reviewed under the Resident Assessment task.</p> <p>This deficient practice had the potential to result in care that does not address the residents' specific care needs.</p> <p>Findings:</p> <p>a. During a review of Resident 75's admission Record (AR), the AR indicated the facility originally admitted the resident on 8/2/2023 and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), hypokalemia (a condition characterized by abnormally low levels of potassium in the blood), and tachycardia (a condition where the heart beats faster than normal).</p> <p>b. During a review of Resident 113's AR, the AR indicated the facility admitted the resident on 1/17/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), generalized anxiety disorder (a mental health condition characterized by excessive, persistent, and often unrealistic worry about everyday things), and encephalopathy (a broad range of conditions that affect brain function, causing changes in thinking, behavior, and physical abilities).</p> <p>c. During a review of Resident 110's AR, the AR indicated the facility admitted the resident on 1/20/2025 with diagnoses including encephalopathy, dementia, and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements).</p> <p>d. During a review of Resident 85's AR, the AR indicated the facility admitted the resident on 1/22/2025 with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia.</p> <p>e. During a review of Resident 74's AR, the AR indicated the facility originally admitted the resident on 6/22/2021 and readmitted on [DATE] with diagnoses including dementia, schizoaffective disorder, and generalized muscle weakness.</p> <p>f. During a review of Resident 107's AR, the AR indicated the facility admitted the resident on 1/26/2025 with diagnoses including dementia, migraine (a neurological disease that causes recurring, severe headache), and generalized muscle weakness.</p> <p>During an interview on 6/18/2025 at 11:40 a.m. with the MDS Coordinator (MDSC), the MDSC stated for Residents 107, 110, 113, 85, 75, and 74's MDS Assessments were not exported timely and exported the assessments today, 6/18/2025.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/20/2025 at 8:43 a.m. with the MDSC, the Centers of Medicare and Medicaid Services' (CMS - a federal agency that administers major healthcare programs) Submission Report: MDS Final Validation Report (a system-generated document that details the results of the automated validation process for submitted MDS assessments) and MDS Assessments were reviewed for the following residents:</p> <ol style="list-style-type: none"> 1. Resident 75 Resident 75's MDS admission Assessment (ADM) indicated a target date of 8/5/2024 and a submission date of 8/14/2025. The MDSC stated the ADM was completed late should have been submitted on 8/8/2024 to be on time. Resident 75's MDS Quarterly Assessment (QTR), dated 11/5/2024, indicated the assessment was completed on 11/26/2024. The MDSC stated completing the assessment after 11/18/2024 is late. 2. Resident 113 Resident 113's MDS ADM, dated 1/30/2025, indicated the assessment was completed late on 2/4/2025. The MDSC stated the assessment should have been signed on 2/4/2025. The MDSC stated she did not verify that the assessment was uploaded to the third-party system the facility uses to submit the MDS Assessments. 3. Resident 110 Resident 110's MDS ADM, dated 2/2/2025, indicated the assessment was submitted 2/7/2025. The MDSC stated the assessment should have been completed 2/2/2025, but it was completed late on 2/7/2025. The MDSC stated Resident 110's MDS QTR, dated 5/5/2025, was submitted late on 6/18/2025. 4. Resident 85 Resident 85's MDS ADM, dated 2/3/2025, indicated the assessment was completed late. The MDSC stated the assessment should have been completed on 2/4/2025, but was completed on 2/7/2025. 5. Resident 74 Resident 74's MDS QTR, dated 7/26/2024, indicated the assessment was completed late. The MDSC stated the assessment was submitted on 8/14/2024 and should have been completed 8/8/2024. Resident 74's MDS QTR, dated 10/21/24, indicated the assessment was completed late. The MDSC stated the assessment should have been completed on 11/3/2024. 6. Resident 107 Resident 107's MDS QTR, dated 5/1/2025, was reviewed and the MDSC stated it was completed timely but was submitted late. The MDSC stated it should have been submitted on 5/30/2025 and after 5/30/2025 is considered late. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/20/2025 at 9:16 a.m., the MDSC stated the facility wants to be compliant with MDS Assessments to accurately reflect the residents' level of care and the profile of their facility, types of residents, and accurate assessment of the facility and types of residents the facility cares for. The MDSC stated the facility could give an inaccurate assessment of the resident and the care they may need to provide. The MDSC stated this information is submitted to CMS and available to the Health Department and nursing home compare website and would reflect in their star-rating. The MDSC stated the public would know what types of residents they would care for and if their loved ones needed placement, they can find information about their facility. The MDSC stated the MDS creates different assessment such as quality measures, facility assessment such as falls and admission rates, and types of medications administered in the facility.</p> <p>During an interview on 6/20/2025 at 2:40 p.m. with the Director of Nursing (DON), the DON stated the facility needs to follow the Medicare guidelines and ensure MDS Assessments are done and completed within 14 days. The DON stated the MDSC is responsible for ensuring completion and transmission of MDS Assessments. The DON stated the importance of following the submission timeline is to give the facility a guideline of the types of residents the facility has, the appropriate assessment is done, and the facility is following federal regulations and providing care to the residents. The DON stated the facility potentially has residents that are covered under Medicare and Medi-Cal services, and CMS needs to be informed about the care the residents are receiving and accepted by CMS. The DON stated if the MDS completion is late, the care plan is done late and the facility will miss some types of interventions.</p> <p>During a review of the CMS Resident Assessment Instrument Manual, dated 10/2024, the CMS Resident Assessment Instrument Manual indicated the following timeframes:</p> <ul style="list-style-type: none"> - admission (Comprehensive): MDS completion date 14th calendar day of the resident's admission (admission date +13 calendar days); Care Plan Completion Date no later than CAA Completion Date +7 calendar days; Transmission Date no later than Care Plan Completion Date +14 calendar days. - Annual (Comprehensive): MDS completion date Assessment Reference Date (ARD) + 14 calendar days; Care Plan Completion Date no later than CAA completion date +7 calendar days; Transmission Date no later than Care Plan Completion Date +14 calendar days. - Quarterly (Non-Comprehensive): MDS Completion Date ARD + 14 calendar days; Transmission Date no later than MDS Completion Date +14 calendar days. <p>During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, last reviewed 7/2024, the P&P indicated the facility will conduct and submit resident assessments in accordance with current federal, state submission timeframes. The P&P indicated timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.</p>		

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 06/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for three of eleven sampled residents (Residents 116, 81 and 70) by:</p> <p>a. Failing to implement Resident 116 ' s care plan on the use of wheelchair pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) on 6/17/2025 and 6/18/2025 as per physician order.</p> <p>b. Failing to ensure a care plan was developed for Resident 116 ' s behavior of removing the bed pad alarm.</p> <p>c. Failing to ensure a care plan was developed for Resident 116 ' s use of Ativan (medication used to treat anxiety [common human emotion characterized by feelings of worry, nervousness, or unease, often about an event with an uncertain outcome] and related conditions) and Haldol (medication used to treat nervous, emotional, and mental conditions).</p> <p>d. Failing to develop and implement a comprehensive care plan on Resident 81 ' s use of restraint pad/tab alarm (a device that alerts caregivers or staff when someone, often elderly or with mobility issues, attempts to get out of a bed or chair) reviewed for physical restraints (are methods, devices, or actions used to restrict a person's movement).</p> <p>e. Failing to develop and implement a comprehensive care plan on Resident 70 ' s use of antibiotic (Cephalexin HCl) reviewed for unnecessary medications.</p> <p>These failures had the potential for delays in the delivery of necessary care and services, could potentially result to accidents like fall and injury, and residents develop adverse effects (an undesired effect of a drug or other type of treatment, such as surgery).</p> <p>Findings:</p> <p>a. During a record review of Resident 116 ' s admission Record, the admission Record indicated the facility admitted Resident 116 on 10/15/2024, with diagnoses that included unspecified (unconfirmed) cerebrovascular disease (a group of conditions that affect blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia (reduced blood flow to the brain, which damages brain tissue and impairs cognitive functions).</p> <p>During a review of Resident 116 ' s History and Physical Examination (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) Visit, dated 10/15/2024, the H&P indicated Resident 116 was alert and needed visual cues (non-verbal signals that provide information, guide actions, or enhance understanding through visual elements).</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 116 Minimum Data Set (MDS-a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 116 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 116 needed maximum assistance from staff for toileting and personal hygiene. The MDS indicated Resident 116 was frequently incontinent (unable to control) bowel and bladder functions. The MDS indicated Resident 116 used bed and chair alarm.</p> <p>During a review of Resident 116 ' s Physician Order, dated 5/15/2025, the Physician Order indicated use of wheelchair with pad alarm when out of bed to alert staff Resident 116 was getting up unassisted to prevent fall every shift.</p> <p>During a review of Resident 116 Change of Condition (COC-a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status) Interact Assessment Form, dated 6/1/2025, the COC indicated on 6/1/2025, at 8:28 p.m., Certified Nursing Assistant 1 (CNA 1) witnessed Resident 116 stood up from the wheelchair in the hallway unassisted and fell on the floor.</p> <p>During an observation on 6/17/2025, at 9:14 a.m., in the lower dining room, Resident 116 seated on a wheelchair with no pad alarm noted.</p> <p>During a concurrent observation, and interview on 6/18/2025, at 6:42 a.m., outside Resident 116 room with Licensed Vocational Nurse 1 (LVN 1), observed Resident 116 seated on a wheelchair at the hallway outside of Resident 116 ' s room with no wheelchair pad alarm. LVN 1 checked Resident 116 wheelchair and stated Resident 116 had no wheelchair pad alarm.</p> <p>During a concurrent interview, and record review on 6/18/2025, with LVN 4, Resident 116 Care Plan dated 10/25/2024 was reviewed. LVN 4 stated care plan on the use of the wheelchair pad alarm was developed on 10/25/2024 and was still active.</p> <p>During an interview on 6/18/2025, at 10:39 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 116 had an order for wheelchair pad alarm to alert staff for Resident 116 ' s safety. The ADON stated if Resident 116 had no wheelchair pad alarm, Resident 116 can get up and possibly fall. The ADON stated fall could lead to possible injury.</p> <p>During an interview on 6/18/2025, at 1:30 p.m., with the Director of Nursing (DON), the DON stated Resident 116 had a physician order and a care plan on the use of wheelchair pad alarm to alert staff when Resident 116 attempts to get up by himself (Resident 116) to lower Resident 116 risk of fall.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the DON, facility ' s policy and procedure (P&P), tilted, Alarm Monitor undated and last reviewed on 7/2024, the P&P indicated, This facility may use alarm monitor as one of the less restrictive measures to alert staff member and provide immediate assist as needed. The type of alarm to be used: tab alarm, pad alarm, alarm in wheelchair and alarm in bed. The staff will apply the alarm to the resident, following the manufacture's instruction, to ensure its functionalists. The DON stated the wheelchair pad alarm was used to alert staff that Resident 116 was attempting to get up without assistance. The DON stated Resident 116 can get up, fall and sustain injury if no wheelchair pad alarm was used.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. During a review of Resident 116 ' s Care Plan, dated 10/17/2024, on resident at risk for recurrent fall/injury, the Care Plan indicated an intervention to use wheelchair with pad alarm when out of bed to alert staff of resident getting up unassisted.</p> <p>During a review of Resident 116 ' s COC dated 6/12/2025, the COC indicated on 6/13/2025, at 12:15 a.m., Resident 116 fell. The COC indicated Registered Nurse 3 (RN 3) heard a sound and found Resident 116 removed his (Resident 116) bed pad alarm.</p> <p>During an interview on 6/20/2025, at 8:17 a.m., with LVN 5, LVN 5 stated on 6/13/2025, at 12:15 a.m., LVN 5 heard a sound and found Resident 116 on the floor. LVN 5 stated there was no bed alarm sound heard before the fall.</p> <p>During an interview on 6/20/2025, at 8:48 a.m., with RN 3, RN 3 stated on 6/13/2025, at 12:15 a.m., Resident 116 bed pad alarm wire was disconnected from the bed alarm machine. RN 3 stated she (RN 3) thought Resident 116 disconnected his (Resident 116) bed alarm. RN 3 stated she (RN 3) did not develop a care plan of Resident 116 ' s removal of bed alarm.</p> <p>During an interview on 6/20/2025, at 9:59 a.m., with RN 1, RN 1 stated there was no care plan developed on Resident 116 behavior of removing his (Resident 116) bed alarm. RN 1 stated there should be a care plan on Resident 116 attempt to remove and disconnect his (Resident 116) bed alarm. RN 1 stated the importance of developing a care plan was to list the interventions on what to do when Resident 116 removes his (Resident 116) bed alarm to prevent a fall. RN 1 stated Resident 116 could possibly fall because the intervention was not there to prevent fall.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the DON, facility P&P titled, Comprehensive Person-Centered Care Plans, dated 3/2022, and last reviewed on 7/2024, 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</p> <p>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.</p> <p>10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.</p> <p>11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.</p> <p>12. The interdisciplinary team reviews and updates the care plan:</p> <p>a. when there has been a significant change in the resident's condition;</p> <p>b. when the desired outcome is not met;</p> <p>c. when the resident has been readmitted to the facility from a hospital stay; and</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. at least quarterly, in conjunction with the required quarterly MDS assessment.</p> <p>13. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. The DON stated staff should have developed a care plan on Resident 116 removal of bed alarm.</p> <p>c. During a review of Resident 116 ' s Physician Order, dated 5/4/2025, the Physician Order indicated Ativan oral tablet 0.5 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give 0.5 mg by mouth every four hours as needed for anxiety manifested by restlessness causing shortness of breath.</p> <p>During a review of Resident 116 ' s Physician Order, dated 5/6/2025, the Physician Order indicated Haldol lactate oral concentrate 2 mg/milliliter (ml- unit of volume, one milliliter is equal to one thousandth of a liter), given 0.5 ml by mouth every four hours as needed for anxiety or nausea (the feeling of sickness in the stomach and the urge to vomit).</p> <p>During a concurrent interview, and record review on 6/18/2025, at 10: 16 a.m., with the ADON, Physician Order dated 5/4/2025 to 5/6/2025 and Care Plans were reviewed. The ADON stated there was no care plan developed on the use of Ativan and Haldol.</p> <p>During an interview on 6/20/2025, at 9:37 a.m. with RN 1, RN 1 stated a care plan should have been developed on the use of Ativan and Haldol because the facility needs to prove that there was a problem that needed the use of the Ativan and Haldol.</p> <p>During an interview on 6/20/2025, at 12:34 p.m., with the DON, the DON stated there should be a care plan developed on the use of Ativan and Haldol so the facility can plan on how to approach a resident if medication was administered, plan on how to handle the resident and provide care.</p> <p>During a review of facility ' s P&P titled, Comprehensive Person-Centered Care Plans, dated 3/2022, and last reviewed on 7/2024, the P&P indicated, .7. The comprehensive, person-centered care plan:</p> <p>a. includes measurable objectives and timeframes;</p> <p>b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including:</p> <p>(1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; .</p> <p>(3) which professional services are responsible for each element of care;</p> <p>c. includes the resident's stated goals upon admission and desired outcomes;</p> <p>d. builds on the resident's strengths; and</p> <p>e. reflects currently recognized standards of practice for problem areas and conditions.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. During a review of Resident 81 ' s admission Record, the admission Record indicated the facility admitted the resident on 2/18/2025, with diagnoses including Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), muscle weakness, and history of falling.</p> <p>During a review of Resident 81 ' s H&P, dated 2/19/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 81 ' s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self understood and understand others and had impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated Resident 81 was dependent to needing substantial assistance on mobility and activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 81 ' s Fall Risk Assessment, dated 5/27/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 81 ' s Order Summary Report, dated 6/20/2025, the Order Summary Report did not indicate any order for pad/tab alarm.</p> <p>During a review of Resident 81 ' s Care Plan Report titled Resident is at risk for falls/injury, last revised on 2/18/2025, the Care Plan indicated an intervention to visibly observe resident frequently.</p> <p>During a concurrent observation, and interview on 6/16/2025, at 10:09 a.m., with Restorative Nursing Assistant (RNA) 2, inside Resident 81 ' s room, observed Resident 81 had a pad/tab alarm in bed and the pad sensor alarm wires were broken and not connected to the alarm unit. RNA 2 stated that the pad/tab alarm was placed on the resident ' s bed because the resident was a high risk for fall. RNA 2 stated the pad/tab alarm alerts the staff if the resident is getting out of bed without assistance.</p> <p>During a concurrent interview, and record review on 6/18/2025, at 10:06 a.m., with RN 1, reviewed Resident 81 ' s Care Plans. RN 1 stated there was no comprehensive care plan developed and implemented on the use of restraint pad/tab alarm on the resident. RN 1 stated it was important to have a comprehensive care plan on the use of tab/pad alarm to ensure appropriateness of its use and to standardize the care provided to the resident. RN 1 stated the care plan serves as a communication tool to all healthcare providers to provide appropriate care.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the DON, the DON stated it was important to develop and implement a comprehensive care plan on the use of restraint pad/tab alarm on Resident 81 to ensure its safe use. The DON stated the care plan serves as a guide to all clinicians on what appropriate interventions are to be provided to the resident to standardize the care to achieve their desired goals.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's recent P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 7/2024, 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. The comprehensive, person-centered care plan is developed within seven days.</p> <p>During a review of the facility's recent P&P titled Use of Restraints, last reviewed on 7/2024, the P&P indicated physical restraints are defined as any manual method of physical or mechanical, device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restrict normal access to one's body. Prior to placing a resident in restraints, there shall be an assessment and a review to determine the need for restraints. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following:</p> <ul style="list-style-type: none"> a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint, <p>Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.</p> <p>e. During a review of Resident 70 ' s admission Record, the admission Record indicated the facility admitted the resident on 10/31/2023, and readmitted the resident on 6/13/2025, with diagnoses including chronic osteomyelitis (a long-term infection of the bone that can cause pain, swelling, and other problems) of left ankle and foot, type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer, and methicillin resistant staphylococcus aureus (MRSA, a bacteria that does not respond to antibiotics) infection.</p> <p>During a review of Resident 70 ' s H&P, dated 6/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 70 ' s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self understood and understand others and had impaired cognition. The MDS indicated the resident was on a high-risk drug class antibiotic.</p> <p>During a review of Resident 70 ' s Order Summary Report, dated 6/15/2025, the Order Summary Report indicated an order of Cephalexin tablet 500 mg, give 500 mg by mouth every six hours for bilateral foot infection until 6/27/2025, at 11:59 p.m. Take first dose on 6/15/2025 at 1200 from emergency kit (e-kit, is essentially a small collection of medications and medical supplies kept on hand to address sudden or worsening symptoms that require immediate attention).</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview, and record review on 6/18/2025, at 11:31 a.m., with RN 4, reviewed Resident 70 ' s Order Summary Report and Care Plans. RN 4 stated there was an order for antibiotic cephalexin tablet 500 mg however, there was no care plan developed and implemented on the use of the antibiotic (cephalexin). RN 4 stated it was important to develop and implement a care plan on the use of cephalexin to monitor for its effectiveness and their adverse effects to report to the primary physician to mitigate the adverse effects timely. RN 4 stated the care plan serves as a communication tool for all healthcare disciplines to eliminate unnecessary interventions to residents.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the DON, the DON stated it was important to develop and implement a comprehensive care plan on the use of antibiotic (cephalexin) on Resident 70 to ensure its safe use. The DON stated the care plan serves as a guide to all clinicians on what appropriate interventions are to be provided to the resident to standardize the care to achieve their desired goals.</p> <p>During a review of the facility's recent P&P titled Care Plans, Comprehensive Person-Centered, last reviewed on 7/2024, 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. The comprehensive, person-centered care plan is developed within seven days.</p>		

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 06/20/2025
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care in accordance with professional standards of practice as indicated in the resident ' s care plans by failing to check a resident ' s gastrostomy tube (g-tube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems) placement before administering medications for one of seven sampled residents (Resident 61) reviewed under Medication Administration facility task.</p> <p>This deficient practice had the potential for Resident 61 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have).</p> <p>Findings:</p> <p>During a review of Resident 61 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 2/13/2024 and readmitted on [DATE] with diagnoses including Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and attention to gastrostomy.</p> <p>During a review of Resident 61 ' s History and Physical (H&P), dated 4/12/2025, the H&P indicated the resident was unable to make decisions.</p> <p>During a review of Resident 61 ' s Minimum Data Set (MDS-a resident assessment tool), dated 4/25/2025, the MDS indicated the resident had unclear speech, adequate hearing, sometimes had the ability to understand others, and rarely/never make self understood. The MDS indicated Resident 61 had a feeding tube as a nutritional approach while a resident of the facility.</p> <p>During a review of Resident 61 ' s Order Summary Report, the Order Summary Report indicated the following:</p> <ol style="list-style-type: none"> 1. Cranberry (supplement) tablet 450 milligrams (mg-a unit of measurement). Give 1 tablet via g-tube one time a day for urinary tract infection (UTI-an infection in the bladder/urinary tract) Prophylaxis, dated 4/10/2025. 2. OcuSoft Lid Scrub Plus External Pad (Eyelid Cleansers). Apply to each eye topically in the morning for blepharitis (inflammation of the eyelids), dated 4/10/2025. 3. Memantine HCl (used to treat symptoms of Alzheimer ' s disease) oral tablet 5 mg. Give 5 mg via g-tube two times a day for Alzheimer's Dementia, dated 4/10/2025. <p>During a review of Resident 61 ' s Care Plan (CP) focused on g-tube stoma (an opening on the surface of the abdomen) noted with hypergranular (a type of healing tissue that forms during wound repair) tissue, with revised date of 5/18/2025, the CP indicated Resident 61 with goals of receiving adequate nutrition and hydration for weight and height daily. The CP indicated interventions including checking and maintaining placement and patency of g-tube.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 61 ' s Medication Administration Record (MAR-a record of medications administered to residents), for 6/2025, the MAR indicated the scheduled time for Resident 61 ' s medications to be given at 9 a.m. included Cranberry, Memantine, and Ocusoft lid scrub.</p> <p>During a concurrent observation and interview on 6/18/2025 at 9:07 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following medications for Resident 61: Cranberry 450 mg, 1 tab and Memantine 5 mg, 1 tab. LVN 1 stated he will administer Ocusoft lid scrub after the g-tube medications. LVN 1 stated he has a total of 2 tablets and one lid scrub to give.</p> <p>During a concurrent observation and interview on 6/18/2025 at 9:17 a.m. with LVN 1, at Resident 61 ' s bedside, LVN 1 put on gown and gloves, disconnected the g-tube feeding machine. LVN 1 pushed air to Resident 61 ' s g-tube using the enteral (the administration of substances, such as medications, directly into the gastrointestinal tract) syringe and no residual noted. LVN 1 stated he will flush with 30 milliliters (ml-a unit of measurement) of water before and after medications and flush in between. LVN 1 flushed Resident 61 ' s g-tube with 30 ml of water then administered memantine then cranberry flushed with water in between and post-flush 30 ml of water. LVN 1 closed the valve on Resident 61 ' s g-tube. LVN 1 removed his gown and gloves and performed hand washing with soap and water. LVN 1 put on new gown and gloves and applied Ocusoft lid scrub on both eyes. LVN 1 stated he completed medication administration for Resident 61.</p> <p>During an interview on 6/18/2025 at 9:39 a.m. with LVN 1, LVN 1 stated he did not use a stethoscope to check for Resident 61 ' s g-tube placement. LVN 1 stated before injecting air into the g-tube he would use the stethoscope to listen in for placement.</p> <p>During an interview on 6/20/2025 at 12:35 p.m. with the Director of Nursing (DON), the DON stated the process of g-tube administration included the charge nurse to check for g-tube placement including hold the g-tube feeding and push 30 ml of air using the enteral syringe and should use stethoscope to listen. The DON stated the purpose of checking the g-tube placement is to ensure medications are administered directly in the resident ' s gastric area and if it is not checked the medications could go into the wrong area and may cause aspiration, peritoneal area, which can cause sepsis (a life-threatening blood infection).</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Administering Medications through an Enteral Tube, dated 7/2024, the P&P indicated the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. The P&P indicated in the procedure to verify placement of feeding tube.</p>		

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 06/20/2025
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide quality of care in accordance with professional standards of practice to meet the resident ' s physical, mental, psychosocial needs (encompass the emotional and social requirements that individuals have to feel safe, supported, and function effectively in their environment) for one of three sampled resident (Resident 116) by:</p> <ol style="list-style-type: none"> 1. Failing to ensure nurses follow physician order to monitor Resident 116 for orthostatic hypotension (also known as postural hypotension, is a sudden drop in blood pressure that occurs when you stand up after sitting or lying down) every Tuesday. No blood pressure documentation on 6/3/2025 (Tuesday), 6/10/2025 (Tuesday), and 6/17/2025 (Tuesday) on a lying position. 2. Failing to ensure neurocheck (a series of quick assessments performed by nurses to evaluate a patient's neurological status [anything related to the nervous system, which includes the brain, spinal cord, and nerves]) was assessed after Resident 116 fall on 6/13/2025. No neurocheck documentation on 6/13/2025, at 6 a.m., 6/14/2025 at 12 a.m., 6/14/2025, at 8 a.m., 6/15/2025, at 12 a.m., 6/15/2025, at 8 a.m., 6/15/2025, at 4 p.m., and 6/16/2025, at 12 a.m. 3. Failing to rotate (a method to ensure repeated injections are not administered in the same area) insulin (a hormone that lowers the level of sugar in the blood) injection administration sites each time insulin was administered for one of three sampled residents (Resident 96). <p>These failures had the potential to result in a delay of care and services for Resident 116 and for Resident 96 to experience adverse effects, such as lipohypertrophy (when fatty tissue builds up under the skin and delays the effect of the injected medication).</p> <p>Findings:</p> <p>a. During a record review of Resident 116 ' s admission Record, the admission Record indicated the facility admitted Resident 116 on 10/15/2024, with diagnoses that included unspecified (unconfirmed) cerebrovascular disease (a group of conditions that affect blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia (reduced blood flow to the brain, which damages brain tissue and impairs cognitive functions).</p> <p>During a review of Resident 116 ' s History and Physical Examination (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) Visit, dated 10/15/2024, the H&P indicated Resident 116 was alert and needed visual cues (non-verbal signals that provide information, guide actions, or enhance understanding through visual elements).</p> <p>During a review of Resident 116 ' s Order Summary Report, dated 10/22/2024, the Order Summary Report indicated the following order:</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Monitor for orthostatic hypotension on day shift. Call the physician if there is a 20 millimeter mercury (mmhg-a unit of measurement) drop in systolic blood pressure (sbp-the top number in a blood pressure reading, representing the pressure in your arteries when your heart beats) or a drop of 10 mmhg in diastolic blood pressure (dbp-the bottom number in a blood pressure reading, representing the pressure in the arteries when the heart is resting between beats) between two readings, every Tuesday on lying position.</p> <p>Monitor for orthostatic hypotension on day shift. Call the physician if there is a 20 mmhg drop in sbp or a drop of 10 mmhg in dbp between two readings, every Tuesday on sitting position.</p> <p>During a review of Resident 116 Minimum Data Set (MDS-a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 116 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 116 was on antidepressant (medication used to treat depression and other mental health condition) medication.</p> <p>During a concurrent interview, and record review on 6/18/2025, at 10:16 a.m., with the Assistant Director of Nursing (ADON), Resident 116 ' s Physician Order, dated 10/22/2024, Medication Administration Record (MAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2025 and Weights and Vitals Summary, dated 6/2025 were reviewed. The MAR indicated no blood pressure documentation on 6/3/2025, 6/10/2025 and 6/17/2025 on a lying position. The ADON stated there were no documented blood pressure of Resident 116 on a lying position on 6/3/2025, 6/10/2025 and 6/17/2025. The ADON stated nurses need to document the blood pressure of Resident 116 on a lying position as ordered by the physician. The ADON stated nurses did not document the blood pressure therefore it was not done. The ADON stated the importance of checking the blood pressure on two separate position (lying and sitting) was to know if Resident 116 had stable blood pressure before medication administration. The ADON stated if Resident 116 was not monitored for orthostatic hypotension, nurses would not be able to know if Resident 116 was experiencing adverse reaction (any unwanted, harmful, or unintended response to a drug) and can result in delay in physician notification and delay in treatment.</p> <p>During an interview on 6/18/2025, at 1:24 p.m., with the Director of Nursing (DON), the DON stated nurses did not follow the physicians order to monitor Resident 116 for orthostatic hypotension. The DON stated the nurses need to identify if Resident 116 had orthostatic hypotension so preventive measures on what was the cause of the orthostatic hypotension could be developed.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the DON, facility ' s policy and procedure (P&P) titled, Orthostatic Hypotension Policy, undated and last reviewed on 7/2024, the P&P indicated, To ensure that resident who are at risk for orthostatic hypotension receive the proper care. The license nurse will carry out the orders for monitoring orthostatic hypotension if physician orders. The license nurse will check and document the orthostatic hypotension order in the MAR. The orthostatic hypotension monitoring will include the blood pressure in lying position and sitting position (May take blood pressure in standing position if indicated or appropriate). Notify the physician if a drop of 20 mmhg for systolic blood pressure and/or a drop of 10 mmhg of diastolic blood pressure from lying position to sitting position and adjust the treatment plan as indicated. The licensed nurse will develop and create a care plan if orthostatic hypotension is identified. The DON stated resident on psychotropic medications (medications that affect the brain's activity and are used to treat mental illnesses like depression) need to be assess for orthostatic hypotension once a week on a lying and sitting position. The DON stated nurses need to check Resident 116 blood pressure on a lying position, wait five minutes and recheck the blood pressure on the same arm and if there was a 20 mmhg difference then it means Resident 116 was positive for orthostatic hypotension. The DON stated Resident 116 was not monitored that could result to Resident 116 getting dizzy causing him (Resident 116) to fall. The DON stated if orthostatic hypotension was not monitored, nurses could miss a change in condition and could result to a possible delay in intervention.</p> <p>During a review of facility ' s P&P titled, Psychotherapeutic Medications, undated and last reviewed on 7/2024, the P&P indicated, Evaluate the resident's response to psychotropic medication therapy (. Antidepressant .) to determine that the medications are appropriate, and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The licensed nurse will assess resident to ensure .</p> <p>F. Actual behavior manifestation and potential side effects being monitored.</p> <p>During a review of facility ' s P&P, titled, Antipsychotic Medication Use, dated 2001 and last reviewed on 7/2024, the P&P indicated, 18. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the attending physician . b. Cardiovascular: orthostatic hypotension, arrhythmias (irregular heartbeats) .</p> <p>b. During a review of Resident 116 ' s [NAME] of Condition (COC-refers to a sudden illness or decline in a resident's health status), dated 6/12/2025, the COC indicated on 6/13/2025, at 12:15 a.m., Resident 116 fell.</p> <p>During a review of Resident 116 ' s 72 Hour Neuro-Check, dated 6/13/2025, the 72 Hour Neuro-Check indicated missing neurocheck assessment on the following dates and times;</p> <p>6/13/2025 at 6 a.m.</p> <p>6/14/2025 at 12 a.m.</p> <p>6/14/2025 at 8 a.m.</p> <p>6/15/2025 at 12 a.m.</p> <p>6/15/2025 at 8 a.m.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6/15/2025 at 4 p.m.</p> <p>6/16/2025 at 12 a.m.</p> <p>During an interview on 6/20/2025, at 8:17 a.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated she (LVN 5) got distracted on 6/13/2025, at 6 a.m., with another phone call and did not complete the neurocheck. LVN 5 stated the importance of checking Resident 116 ' s neurocheck after fall was to find out if there was a change in level of consciousness (loc-refers to a person's awareness and responsiveness to their surroundings) and change in vital signs (measurements of the body's most basic functions). LVN 5 stated not checking Resident 116 neurocheck after fall, nurses might miss a change in Resident 116 condition and delays physician notification. LVN 5 stated she (LVN 5) did not follow the post (after) fall protocol and could result in a delay in care.</p> <p>During an interview on 6/20/2025, at 9:59 a.m., with Registered Nurse 1 (RN 1), RN 1 stated there were seven times Resident 116 ' s neurocheck was not assessed in a 72-hour period after 6/13/2025 fall. RN 1 stated the importance of neurocheck was to check the condition of the resident after a fall. RN 1 stated nurses could miss Resident 116 ' s change in condition and delays the physician notification.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the DON, facility ' s P&P, titled, Neurological Assessment, dated 10/2010, and last reviewed on 7/2024, the P&P indicated, 1. Neurological assessments are indicated:</p> <ol style="list-style-type: none"> a. Upon physician order; b. Following an unwitnessed fall; c. Following a fall or other accident/injury involving head trauma; or d. When indicated by resident's condition. <ol style="list-style-type: none"> 2. When assessing neurological status, always include frequent vital signs. Particular attention should be paid to widening pulse pressure (difference between systolic and diastolic pressures). This may be indicative of increasing intracranial pressure (ICP-the pressure inside your skull, exerted by your brain). 3. Any change in vital signs or /neurological status in a previously stable resident should be reported to the physician immediately. The DON stated neurocheck should be done for 72 hours after fall. The DON stated the nurses need to do a neurocognitive (refers to the mental processes involved in thinking, learning, and remembering) assessment to early identify head trauma for unwitnessed fall. The DON stated the policy did not mention that neurocheck should be for 72 hours but it ' s what the facility follows. <p>During a review of facility ' s P&P, titled, Vital Signs undated and last reviewed on 7/2024, the P&P indicated, Vital signs will be taken on change of condition, including neurological checks for 72 hours as needed.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. During a review of Resident 96 ' s admission Record, dated 6/20/2025, the admission Record indicated Resident 96 ' s diagnoses include cerebral vascular accident (when blood flow to the brain is blocked or there is sudden bleeding in the brain), diabetes mellitus (DM-a disease where the body is unable to properly control blood sugar levels), hypertension (high blood pressure), and major depressive disorder (a condition in which a person has persistent feelings of sadness, hopelessness, and a loss of interest in activities once enjoyed).</p> <p>During a review of Resident 96 ' s MDS, dated [DATE], the MDS indicated Resident 96 has difficulty communicating some words or finishing thoughts. The MDS indicated Resident 96 is dependent to needing substantial assistance on mobility and activities of daily living (ADLs &ndash; such as bathing, dressing and toileting a person performs daily).</p> <p>During a concurrent interview and record review on 6/20/2025 at 9:55 a.m. with LVN 7, Resident 96 ' s Order Summary Report, dated 6/20/2025, were reviewed. LVN 7 stated the Order Summary Report indicated that regular insulin is to be injected subcutaneously (the area located just beneath the skin) before meals and at bedtime to treat Resident 96 ' s DM, and to rotate injection sites each time an injection is given. LVN 7 stated the Order Summary Report also indicated insulin glargine solution to be injected subcutaneously at bedtime depending on Resident 96 ' s blood sugar level, and to rotate injection sites.</p> <p>During a concurrent interview and record review on 6/20/2025 at 9:59 a.m. with LVN 7, Resident 96 ' s Location of Administration Report, for the month of 4/2025 and 5/2025, were reviewed. LVN 7 stated the facility failed to rotate the injection sites when giving insulin injections to Resident 96 on the following dates: 4/18/2025, 4/19/2025, 4/20/2025, 4/21/2025, 4/22/2025, 5/3/2025, 5/4/2025, 5/5/2025, and 5/31/2025. LVN 7 stated the failures to rotate insulin injection sites were performed by multiple, different nurses. LVN 7 stated injecting repeatedly at the same site of the body can make the skin thicker at the injection site, which prevents insulin from being absorbed properly.</p> <p>During a concurrent interview and record review on 6/20/2025 at 1:04 p.m. with the DON, Resident 96 ' s Location of Administration Report, for the month of 4/2025 and 5/2025 were reviewed. The DON stated the facility failed to rotate the injection sites when giving insulin injections to Resident 96 on the following dates: 4/18/2025, 4/19/2025, 4/20/2025, 4/21/2025, 4/22/2025, 5/3/2025, 5/4/2025, 5/5/2025, and 5/31/2025. The DON stated insulin injections may be given in fatty areas of the body such as the abdomen, upper extremities, and anterior portion of the thighs. The DON stated nurses must rotate the injection sites when giving insulin injections to avoid lipohypertrophy, which is a complication resulting in thicker skin that affects the absorption of insulin by the body.</p> <p>During an interview on 6/20/2025 at 1:10 p.m. with the DON, the DON stated rotating insulin injection sites is part of licensed nursing professional practice. The DON stated that if nurses are failing to rotate insulin injections sites, then it means [the facility is] not administering the prescribed medication per the doctor's orders. The DON stated manufacturing specifications for insulin will specify that the insulin administration must be rotated to avoid adverse effects. The DON stated the facility did not follow the MD Orders, professional practice, and manufacturing specifications.</p> <p>During a review of the facility ' s P&P titled, Insulin Administration, dated 7/2024, the P&P indicated: Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).</p>		

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 06/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcer/injury (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one of one sampled resident (Resident 36) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure a thorough skin check of Resident 36 was done upon readmission to the facility on 5/22/2025. 2. Ensure a reassessment of Resident 36 ' s pressure injury was done within 24 hours after readmission. <p>These deficient practices had the potential for a delay of necessary care and services and worsening of Resident 36 ' s pressure injury.</p> <p>Findings:</p> <p>During a review of Resident 36 ' s admission Record, the admission Record indicated the facility admitted the resident on 1/18/2024, and readmitted the resident on 5/22/2025, with diagnoses including pressure-induced deep tissue damage (a type of damage to the skin and underlying tissues, often occurring over bony areas, caused by prolonged pressure) of sacral region (is basically the lower part of your back, just above your tailbone, where your spine connects to your pelvis), mild protein-calorie malnutrition (means that a person is not getting enough protein and energy [calories] from their diet to meet their body's needs, but the condition is not yet severe), and adult failure to thrive (a condition where older adults experience a significant decline in their physical and mental health, marked by weight loss, decreased appetite, and reduced activity).</p> <p>During a review of Resident 36 ' s History and Physical (H&P), dated 5/23/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 36 ' s Minimum Data Set (MDS, a resident assessment tool), dated 5/23/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated Resident 36 was dependent to needing substantial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 26 was incontinent of urine and stool (feces) and was at risk for developing pressure injury. The MDS indicated Resident 36 had an unhealed pressure injury stage 4 (it involves a deep wound that extends through the skin and underlying tissues, potentially exposing muscle, tendon, bone, or other deep structures) on readmission to the facility. The MDS indicated Resident 36 was on skin and ulcer/injury treatment on pressure reducing device for bed, turning/repositioning program, nutrition and hydration intervention to manage skin problems, and pressure ulcer/injury care.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 36 ' s Order Summary Report, dated 6/13/2025, the Order Summary Report indicated an order for treatment on the sacrum (shield-shaped bony structure that is located at the base of the lumbar vertebrae and that is connected to the pelvis) stage 4 pressure ulcer to cleanse with normal saline (a mixture of water and salt with a salt concentration of 0.9%), pat dry, apply zinc oxide paste (is a thick, protective cream or ointment that is applied to the skin) mixed with vitamin A&D ointment (is used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations), then apply bordered silicone super absorbent dressing, and to change daily every day shift for 30 days.</p> <p>During a review of Resident 36 ' s Braden Scale (BS) For Predicting Pressure Sore Risk, dated 5/23/2025, the BS indicated the resident was high risk for pressure injury.</p> <p>During a review of Resident 36 ' s admission Assessment, dated 5/22/2025, the admission Assessment indicated Registered Nurse (RN) 6 documented Resident 36 was noted with bilateral ankle dryness and cracking with bandage for protection. No current skin issues, however, noted with gastrostomy tube (g-tube, is a medical device that provides a way to get nutrition, fluids, and medications directly into the stomach when someone cannot eat or drink enough by mouth).</p> <p>During a review of Resident 36 ' s Wound Evaluation, dated 5/24/2025, the Wound Evaluation indicated Treatment Nurse (TN) 2 documented a pressure injury stage 3 (a deep wound that extends through the skin into the underlying fat tissue) on the sacrum and was present on admission measuring 8.4 centimeters (cm, a unit of measurement) X 3.5 cm X 2.4 cm.</p> <p>During a review of Resident 36 ' s Wound Evaluation, dated 5/28/2025, the Wound Evaluation indicated TN 1 documented a pressure injury stage 4 on the sacrum and was present on admission measuring 8.4 cm X 3.5 cm X 2.4 cm X 0.2 cm (deepest point).</p> <p>During a review of Resident 36 ' s Care Plan (CP) Report titled 5/28/2025, Wound reclassified as stage 4 pressure ulcer on the sacrum, last revised on 5/27/2025 and was resolved on 6/18/2025, the CP indicated an intervention to administer treatment as ordered.</p> <p>During a concurrent interview and record review on 6/18/2025, at 10:49 a.m., with TN 1, reviewed Resident 36 ' s Order Summary Report, Treatment Record, admission Record, and Wound Evaluation. TN 1 stated RN 6 did not do a thorough skin check upon Resident 36 ' s admission on [DATE]. TN 1 also stated TN 2 did not perform within 24 hours a pressure injury reassessment post readmission of Resident 36. TN 1 stated TN 2 did his reassessment on 5/24/2025 and documented stage 3 instead of stage 4 on the sacrum. TN 1 stated she saw Resident 36 on 5/28/2025 and reclassified the pressure injury at the sacrum as stage 4.</p> <p>During an interview on 6/18/2025, at 11:18 a.m., with TN 2, TN 2 stated he does not recall Resident 36 having a pressure injury. TN 2 stated he remembered Resident 36 had history of stage 3 to 4 on the coccyx from previous admissions.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/18/2025, at 12:15 p.m., with RN 6, RN 6 stated she did not perform a thorough skin assessment on Resident 36 on readmission because the resident was refusing to turn on her side. RN 6 stated she wanted to check the skin for another time by telling the Certified Nursing Assistants (CNAs) to call her when they are providing care to the resident to check the resident ' s back. RN 6 stated she was called by the CNAs to check on the resident ' s back but was unable to go at the bedside because she got busy. RN 6 stated she meant to document the refusal of the resident to turn but forgot to document it. RN 6 stated she should have endorsed to the next licensed nurse her failure to examine the skin at the back of the resident to identify the skin issue. RN 6 stated her failure to assess the back of Resident 36 resulted in the delay of care and treatment to the resident.</p> <p>During an observation of Resident 36 ' s Wound Dressing on 6/20/2025, at 9:16 a.m., with TN 1, observed Resident 36 ' s Pressure Injury at the sacrum healed with scar tissue.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the Director of Nursing (DON), the DON stated RN 6 should have performed a thorough skin check on Resident 36, if the resident refused, try to offer again at another time, if unsuccessful document the refusal despite explanation of the risk of refusal to the resident and endorse to incoming licensed nurse for follow up. The DON stated TN 2 should have performed a skin reassessment within 24 hours after admission to ensure the skin was intact and no skin issues were missed. The DON also stated TN 2 should have placed stage 4 instead of stage 3 as Resident 36 came in the facility with stage 4 on initial admission. The DON stated it is important to assess the skin of admitted /readmitted residents in the facility to identify skin issues and to promptly provide treatment to avoid skin complications.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled Prevention of Pressure Injuries, last reviewed on 7/2024, the P&P indicated the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific factors. Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge.</p> <p>During a review of the facility ' s recent P&P titled Skin Breakdown- Policy and Procedure, last reviewed on 7/2024, the P&P indicated the licensed nurse will conduct a body check for all residents after admissions, followed by a body check reassessment by a treatment nurse within 24 hours of admission or at the earliest possible opportunity.</p>		

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 06/20/2025
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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on observation, interview, and record review, the facility failed to ensure its residents with or without limited range of motion (ROM - movement of the joints) receive appropriate treatment and services to increase, prevent, or maintain the ROM mobility for one of three sampled residents (Resident 18) who had a physician's orders for Restorative Nursing Assistant (RNA) exercises and use of left knee splint (a device used to immobilize and support a body part, typically an arm or leg, that has been injured) five times a week.</p> <p>This failure resulted to Resident 18 not receiving RNA exercises and placed him (Resident 18) at risk for decline in physical function and at risk for contractures (a condition where muscles, tendons, or other tissues shorten and tighten, limiting the movement of a joint).</p> <p>Findings:</p> <p>During a review of Resident 18 ' s admission Record, the admission Record indicated the facility admitted Resident 18 on 8/11/2024, with diagnoses that included unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), generalized muscle weakness and unspecified hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the left nondominant side.</p> <p>During a review of Resident 18 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 8/13/2024, the H&P indicated Resident 18 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 18 Minimum Data Set (MDS-a resident assessment tool), dated 4/2/2025, the MDS indicated Resident 18 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 18 was dependent to staff for all activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 18 was on RNA services for ROM.</p> <p>During a review of Resident 18 ' s Physician Order, dated 4/30/2025, the Physician Order indicated the following:</p> <p>RNA to apply left knee splint as tolerated up to four hours followed by skin check every two hours to prevent skin irritation/redness daily five times a week.</p> <p>RNA to provide passive ROM (the movement of a joint through its range of motion by an external force, without the individual actively contracting their muscles) exercises on bilateral lower extremity (legs) as tolerated daily five times a week.</p> <p>During a review of Resident 18 ' s Care Plan, dated 4/30/2025, on limitation in ROM, the Care Plan indicated an intervention for RNA to provide passive ROM exercises to Resident 18 ' s bilateral lower extremity and RNA to apply left knee splint as tolerated up to four hours daily five times a week.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 18 ' s Documentation Survey, dated 6/2025, the Documentation Survey indicated from 6/2/2025, to 6/8/2025, Resident 18 had passive ROM exercises only for three days.</p> <p>During an observation on 6/17/2025, at 10:37 a.m., inside Resident 18 room, observed Resident 18 ' s had contracted left leg, and right leg was extended.</p> <p>During a concurrent interview, and record review on 6/18/2025, at 7:13 a.m., with RNA 1, Resident 18 ' s Documentation Survey, dated 6/2025 was reviewed. The Documentation Survey indicated from 6/2/2025, to 6/8/2025, RNA provided passive ROM exercises to Resident 18 three times only and RNA applied left knee splint to Resident 18 from 6/2/2025 to 6/8/2025, four times. RNA 1 stated Resident 18 had contracted legs, and passive ROM should be provided five times a week. RNA 1 stated Resident 18 also uses left knee splint five times a week. RNA 1 stated RNA must have forgotten to document the missing RNA documentation on the week of 6/2/2025 to 6/8/2025. RNA 1 stated passive ROM exercises and use of splint helps prevent injury and prevent contraction.</p> <p>During an interview on 6/18/2025, at 9:42 a.m., with the Director of Rehabilitation (DOR), the DOR stated RNA should provide passive ROM exercises and apply left knee splint five times a week.</p> <p>During an interview on 6/18/2025, at 2:27 p.m., with Director of Staff Development Assistant 1 (DSDA 1), DSDA 1 stated RNA 1 did not document RNA services. DSDA 1 stated if not documented, passive ROM and splint application was not done. DSDA 1 stated RNA should follow the physician order to prevent delay in care and decline in resident condition.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12: 34 p.m., with the Director of Nursing (DON), facility ' s policy and procedure (P&P) titled, Restorative Nursing Services General Policies, undated and last reviewed on 7/2024, the P&P indicated, A program of Restorative Nursing is provided in our facility under the direction of the rehabilitation team, physician and Director of Nursing and with input as necessary from Social Worker, Dietician. The restorative program is available to any resident in need of these services. Residents who have limited range of motion, or those who have potential for contractures based on limited mobility, will be placed in a restorative program with appropriate devices as determined by the physician, rehab team, and or device specialist as needed Treatment frequency for restorative programs is generally considered to be daily. Daily services refer to the number of days per week restorative nursing is available. This is normally five to seven days per week. Many facilities offer RNA services seven days per week. The therapist or nurse referring the resident to the RNA program determines the frequency of treatment which is medically necessary for the resident. This can be any frequency, one to seven times per week, depending upon the resident's needs. In summary, there are very few rigid rules regarding the operation of facility RNA programs. There are some Medicare requirements of the restorative program. These are: 1. Every resident requiring RNA care must have this service available to him/her. 2. There must be accurate documentation of the treatment being performed, including weekly summaries which reflect the resident's progress and response to treatment. The DON stated RNA services are performed to lower the risk or decline in mobility of ROM. The DON stated RNA exercises lower the chances of Resident 18 for contractures and increases circulation to prevent skin damage.</p>		

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 06/20/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. During a record review of Resident 116 ' s admission Record, the admission Record indicated the facility admitted Resident 116 on 10/15/2024, with diagnoses that included unspecified (unconfirmed) cerebrovascular disease (a group of conditions that affect blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia (reduced blood flow to the brain, which damages brain tissue and impairs cognitive functions).</p> <p>During a review of Resident 116 ' s H&P Visit, dated 10/15/2024, the H&P indicated Resident 116 was alert and needed visual cues (non-verbal signals that provide information, guide actions, or enhance understanding through visual elements).</p> <p>During a review of Resident 116 ' s Care Plan, dated 10/17/2024, on at risk for recurrent fall/injury, the Care Plan indicated an intervention to use wheelchair with pad alarm to alert staff when resident gets up unassisted.</p> <p>During a review of Resident 116 ' s Order Summary Report, dated 10/25/2024, the Order Summary Report indicated a physician order for wheelchair with pad alarm when out of bed to alert staff that resident was getting up unassisted to prevent fall, every shift.</p> <p>During a review of Resident 116 ' s Minimum Data Set (MDS-a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 116 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 116 needed maximum assistance from staff for toileting and personal hygiene. The MDS indicated Resident 116 was frequently incontinent (unable to control) bowel and bladder functions. The MDS indicated Resident 116 used bed and chair alarm.</p> <p>During a review of Resident 116 ' s Change of Condition (COC-a document used to record and report any significant changes in a resident's physical, mental, or psychosocial status) Interact Assessment Form, dated 6/1/2025, the COC indicated on 6/1/2025, at 8:28 p.m., Certified Nursing Assistant 1 (CNA 1) witnessed Resident 116 stood up from the wheelchair in the hallway unassisted and fell on the floor.</p> <p>During a review of Resident 116 ' s COC dated 6/12/2025, the COC indicated on 6/13/2025, at 12:15 a.m., Resident 116 fell. The COC indicated Registered Nurse 3 (RN 3) heard a sound and found Resident 116 removed his (Resident 116) bed pad alarm.</p> <p>During a review of Resident 116 ' s Fall Risk Assessment, dated 6/1/2025 and 6/13/2025, the Fall Risk Assessment indicated Resident 116 was a high risk for fall.</p> <p>During an observation on 6/17/2025, at 9:14 a.m., in the lower dining room, Resident 116 seated on a wheelchair with no pad alarm noted.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation, and interview on 6/18/2025, at 6:42 a.m., outside Resident 116 ' s room with Licensed Vocational Nurse 1 (LVN 1), observed Resident 116 seated on a wheelchair at the hallway outside of Resident 116 room with no wheelchair pad alarm. LVN 1 checked Resident 116 wheelchair and stated Resident 116 had no wheelchair pad alarm.</p> <p>During an interview on 6/18/2025, at 10:39 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Resident 116 had an order for wheelchair pad alarm to alert staff for Resident 116 safety. The ADON stated if Resident 116 had no wheelchair pad alarm, Resident 116 can get up and possibly fall. The ADON stated fall could lead to possible injury.</p> <p>During an interview on 6/18/2025, at 1:30 p.m., with the Director of Nursing (DON), the DON stated Resident 116 had a physician order and a care plan on the use of wheelchair pad alarm to alert staff when Resident 116 attempts to get up by himself (Resident 116) to lower Resident 116 risk of fall.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the DON, facility ' s policy and procedure (P&P), titled, Alarm Monitor undated and last reviewed on 7/2024, the P&P indicated, This facility may use alarm monitor as one of the less restrictive measures to alert staff member and provide immediate assist as needed. The type of alarm to be used: tab alarm (uses a pull-tab that, when removed, triggers an alarm), pad alarm, alarm in wheelchair and alarm in bed. The staff will apply the alarm to the resident, following the manufacture's instruction, to ensure its functionalists. The DON stated the wheelchair pad alarm was used to alert staff that Resident 116 was attempting to get up without assistance. The DON stated Resident 116 can get up, fall and sustain injury because wheelchair pad alarm was not used.</p> <p>During a review of facility ' s P&P, titled, Managing Falls and Fall Risk dated 3/2018, and last reviewed on 7/2024, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk:</p> <ul style="list-style-type: none"> -The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls -In conjunction with the attending physician, staff will identify and implement relevant interventions (hip padding or treatment of osteoporosis [weak and brittle bones due to lack of calcium and Vitamin D], as applicable) to try to minimize serious consequences of falling. -Position-change alarms will not be used as the primary or sole intervention to prevent falls but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During a review of Resident 69 ' s admission Record (AR), the AR indicated the facility originally admitted the resident on 6/24/2021 and most recently admitted the resident on 1/3/2025 with diagnoses that included metabolic encephalopathy a (general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), unspecified dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).</p> <p>During a review of Resident 69 ' s MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated Resident 69 required partial / moderate assistance from staff for bathing, lower body dressing, personal hygiene; and the resident required staff supervision for mobility.</p> <p>During a review of Resident 96 ' s Self-Administration of Drugs Assessment form, dated 1/26/2022, the Self-Administration of Drugs Assessment form indicated the resident needs assistance with all medication administration and was not safe for self-administration of medication.</p> <p>During a review of Resident 69 ' s Care Plan (CP) titled, Rash / Pruritus. Skin integrity impairment manifested by skin rash / pruritis. Location: right upper extremity, initiated 4/23/2025, the CP indicated a goal that eczema would resolve.</p> <p>During a concurrent observation and interview on 6/16/2025 at 10:50 a.m., Resident 69 lay in bed. Observed an individual packet of A&D ointment on Resident 69 ' s nightstand. Resident 69 stated facility staff give Resident 69 the A&D ointment for Resident 69 to apply to the face once a day. Resident 69 pressed the call light (a device used to summon staff for assistance).</p> <p>During an observation on 6/16/2025 at 11 a.m., Restorative Nursing Assistant (RNA) 3 entered Resident 69 ' s room and spoke with the resident. Observed an individual packet of A&D ointment on the resident ' s nightstand. RNA 3 then exited Resident 69 ' s room, observed RNA 3 did not remove the packet of A&D ointment.</p> <p>During a concurrent observation and interview on 6/16/2025 at 11:20 a.m., with the Director of Staff Development (DSD), the DSD entered Resident 69 ' s room and stated there was an individual packet of A&D ointment on the resident ' s nightstand. The DSD stated A&D ointment is considered a medication and residents cannot keep A&D ointment packets in the room for self-administration. The DSD stated staff should assess the resident ' s environment every time the staff enters the room and RNA 3 should have identified the ointment and removed it, but RNA 3 did not.</p> <p>During a concurrent interview and record review on 6/16/2025 at 11:25 a.m., with Registered Nurse (RN) 4, RN 4 reviewed Resident 69 ' s physician orders. RN 4 stated Resident 69 had dryness on the legs with a topical treatment. RN 4 stated Resident 69 did not have an order for A&D ointment, but sometimes the facility Certified Nursing Assistants (CNAs) apply the ointment. RN 4 stated A&D ointment should not be left in a resident ' s room because residents could gain access to the ointment.</p> <p>During a concurrent observation and interview on 6/16/2025 at 11:30 a.m., with RNA 3, RNA 3 stated RNA 3 did not see the A&D ointment in the resident ' s room, but the resident should not have it. Observed RNA 3 entered Resident 69 ' s room and removed the A&D ointment.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/20/2025 at 11:03 a.m., with Treatment Nurse (TN) 1, TN 1 stated residents may not self-administer A&D ointment. TN 1 stated A&D ointment should not be left in a resident ' s room because it is a safety risk to any facility resident. TN 1 stated Resident 69 or any resident may inappropriately apply the ointment or even eat it, causing digestive issues. TN 1 stated all staff are responsible to identify safety issues when providing care. TN 1 stated RNA 3 should have identified the A&D ointment in Resident 69 ' s room.</p> <p>During a concurrent interview and record review on 6/20/2025 at 10:50 a.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding medication administration, medication storage, and resident safety. The DON stated A&D ointment is an over-the-counter medication and should not be stored at a resident ' s bedside for resident self -administration. The DON stated the facility P&P was not followed when A&D ointment was left at Resident 69 ' s bedside potentially resulting in a safety concern when residents ingest the ointment.</p> <p>During a review of the facility P&P titled, Self-Administration of Medications, last reviewed 7/2024, the P&P indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment the IDT assesses each resident ' s cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. Self-administered medications are stored in a safe and secure place which is not accessible by other residents.</p> <p>During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 7/2024, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.</p> <p>During a review of Manufacture 1 ' s A&D Ointment Safety Data Sheet, dated 1/7/2015, the Safety Data Sheet indicated a warning that indicated for external use only. A small number of individuals may experience reactions such as redness, rash, and/or swelling upon prolonged or repeated skin contact or eye contact. Overexposure may cause skin reaction. Ingestion may cause nausea, vomiting, or diarrhea.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for four of five sampled residents (Residents 84, 81, 116, and 69) reviewed for accidents by failing to ensure:</p> <ol style="list-style-type: none"> 1. Resident 84 ' s fall mattress (a cushioned floor pad designed to help prevent injury should a person fall) did not have any furniture or medical equipment on top of them. 2. Resident 81 ' s pad/tab alarm (a device used to alert caregivers when a resident, particularly one at risk of falling, attempts to get out of bed or a chair without assistance) did not have a broken pad alarm sensor cord. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Resident 116 had a wheelchair pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) as per physician order.</p> <p>These deficient practices increased the risk of accidents such as falls with injuries on residents.</p> <p>4. Resident 69 ' s Vitamin A&D Ointment (a topical medication used to treat and prevent various skin irritations) was not left unattended and readily available in the resident ' s shared room.</p> <p>This deficient practice had the potential to result in other residents obtaining medication without staff knowledge resulting in accidental ingestion causing harm to other residents.</p> <p>Findings:</p> <p>1. During a review of Resident 84 ' s admission Record, the admission Record indicated the facility admitted the resident on 3/28/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), epilepsy (a brain condition that causes recurring seizures), and history of falling.</p> <p>During a review of Resident 84 ' s History and Physical (H&P), dated 3/28/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 84 ' s Minimum Data Set (a resident assessment tool), dated 4/7/2025, the MDS indicated the resident usually had the ability to make self understood and understand others and had severe cognitive impairment (when someone has a significant loss of mental abilities, making it hard for them to think, learn, remember, and make decisions, to the point where they can't live independently). The MDS indicated Resident 84 had upper extremity impairment and uses a walker and a wheelchair to ambulate. The MDS indicated Resident 84 was dependent on needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 84 ' s Order Summary Report, dated 3/28/2025, the Order Summary Report indicated an order for low bed (a bed that sits closer to the ground than a traditional bed) with floor mats to decrease potential injury, every shift.</p> <p>During a review of Resident 84 ' s Fall Risk Assessment, dated 3/30/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 84 ' s Care Plan (CP) Report titled, Resident is on low bed with floor mats to decrease potential for injury, last revised on 3/30/2025, the CP indicated a goal to prevent or reduce incident of injury/falls as well as for comfort of getting in and out of bed through the next assessment. The CP indicated an intervention to attempt to use less restrictive devices on an ongoing basis.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/16/2025, at 11 a.m., with Treatment Nurse (TN) 1, inside Resident 84 ' s room, observed Resident 84 ' s bilateral fall mat with the resident ' s wheel of the bed on top of the left fall mat. TN 1 stated the wheel of the bed was on top of the left fall mat. TN 1 stated the wheel on the fall mat can cause a permanent dent on the fall mat decreasing its cushioning effect to prevent injury.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the Director of Nursing (DON), the DON stated there should be no furniture or medical equipment on top of Resident 84 ' s fall mat to prevent falls with injury. The DON also stated placing a heavy object on top of the fall mat can cause a permanent indentation on the fall mat decreasing its ability to lessen the impact of the fall of the resident.</p> <p>During a review of the facility-provided Instructions on the use of Fall Mat 1, dated 3/2023, the Instruction indicated when moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. Sharp objects may cause damage to the mat. Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 7/2024, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization.</p> <p>Resident Risks and Environmental Hazards</p> <p>a. Bed safety;</p> <p>g. Electrical safety</p> <p>2. During a review of Resident 81 ' s admission Record, the admission Record indicated the facility admitted the resident on 2/18/2025, with diagnoses including Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), muscle weakness, and age-related osteoporosis (the development of osteoporosis, a condition characterized by weakened and brittle bones, as a natural consequence of aging).</p> <p>During a review of Resident 81 ' s H&P, dated 2/19/2025, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 81 ' s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self understood and understand others and had impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated Resident 81 was dependent to needing substantial assistance on mobility and ADLs.</p> <p>During a review of Resident 81 ' s Order Summary Report, dated 6/20/2025, the Order Summary Report did not indicate any order for pad/tab alarms in bed.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 81 ' s Fall Risk Assessment, dated 5/27/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 81 ' s Care Plan (CP) report titled Resident is at risk for falls/injury related to dementia, difficulty walking ., last revised on 2/18/2025, the CP indicated an intervention to visibly observe resident frequently and to provide a safe and clutter-free environment.</p> <p>During a concurrent observation and interview on 6/16/2025, at 10:06 a.m., with Restorative Nursing Assistant (RNA) 2, inside Resident 81 ' s room, observed Resident 81 ' s pad/tab alarm with broken sensor pad wires. RNA 2 stated the pad wires should be connected to the monitor and the pad wires were broken with frayed wires. RNA 2 stated she will report the incident to the maintenance staff right away. RNA 2 stated it was the responsibility of the Maintenance Department to ensure the pad/tab alarms are working and not broken. RNA 2 stated with the pad alarm wires not connected and broken the resident will get out of bed without assistance without the staff knowledge and could fall and sustain an injury.</p> <p>During an interview on 6/18/2025, at 7:17 a.m., with the Maintenance Assistant (MA), the MA stated they are not responsible for the pad/tab alarm maintenance and checking on the facility. The MA stated Central Supply is responsible for making sure the pad/tab alarms were working in the facility.</p> <p>During an interview on 6/20/2025, at 12:47 p.m., with the Central Supply Supervisor (CSS), the CSS stated they provide the tab/pad alarms and attachments, but they are not responsible for ensuring the pad/tab alarms attached to residents were working. The CSS stated the nursing staff were responsible for testing and ensuring the pad/tab alarms attached to the residents were functioning.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the DON, the DON stated all staff working on the unit are responsible in ensuring the pad/tab alarms attached to residents are working. The DON stated the staff should test the pad alarm daily for functionality and to check if there are broken accessories that needed to be replaced. The DON stated the failure of the staff to ensure the pad alarm is working and connected to Resident 81 could lead to accidents such as falls.</p> <p>During a review of the facility-provided User's Manual Mobile Monitor 1 (MM 1), mobile monitor, undated indicated to carefully read the instructional manual prior to use. Failure to comply with instructions, warnings and cautions may result in serious injury to patient. Always test system and battery before each use.</p> <p>During a review of the facility-provided Instructions for Use Sensor Pad, undated, indicated to route cords towards the alarm unit, being careful to keep cord clear of moving assist bars, latching mechanisms and all other moving parts. Connect sensor pad to alarm. Test the system operates correctly.</p> <p>During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 7/2024, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident Risks and Environmental Hazards</p> <p>a. Bed safety;</p> <p>g. Electrical safety</p>

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 06/20/2025
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, interview, and record review, the facility failed to offer a therapeutic diet when there was a nutritional problem, and the healthcare provider ordered a therapeutic diet for one of two sampled residents (Resident 70) reviewed under nutrition. The Interdisciplinary Team 's (IDT, is a group of people from different fields or areas of expertise who work together towards a common goal) recommendation in Resident 70 ' s Weight Management Care Plan, dated 6/16/2025, was not followed by failing to obtain a physician ' s order for Glucerna (a brand of meal replacement shakes and bars) 1 can daily (qd).</p> <p>This deficient practice placed Resident 70 at risk for continued weight loss.</p> <p>Findings:</p> <p>During a review of Resident 70 ' s admission Record, the admission Record indicated the facility admitted the resident on 10/31/2023, and readmitted the resident on 6/13/2025, with diagnoses including dysphagia (difficulty swallowing), major depressive disorder (a serious mental health condition characterized by persistent sadness, loss of interest in activities, and a general feeling of low mood that significantly interferes with daily life), and gastro-esophageal reflux disease (is a condition where stomach acid frequently flows back up into the esophagus, causing irritation and symptoms like heartburn).</p> <p>During a review of Resident 70 ' s History and Physical (H&P), dated 6/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 70 ' s Minimum Data Set (MDS, a resident assessment tool), dated 5/13/2025, the MDS indicated the resident sometimes had the ability to make self understood and understand others and had impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated Resident 70 had 5 percent (% - one part in every hundred) or more weight loss and was not on physician-prescribed weight-loss regimen. The MDS indicated the Resident 70 was on a mechanically altered, therapeutic diet.</p> <p>During a review of Resident 70 ' s Order Summary Report, the Order Summary Report indicated an order for:</p> <p>6/13/2025 Consistent or controlled carbohydrate diet (CCHO), No added salt (NAS) diet. Mechanical soft texture. Thin consistency. Large portions.</p> <p>6/19/2025 Sugar free ice cream with meals for weight management with lunch and dinner.</p> <p>The Order Summary Report, dated 6/20/2025, did not indicate an order for Glucerna 1 can qd for 30 days.</p> <p>During a review of Resident 70 ' s Weights and Vitals Summary (WVS) from 12/1/2025 to 6/20/2025, the WVS indicated:</p> <p>6/14/2025 150 pounds (lbs., a unit of weight)</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6/1/2025 158 lbs.</p> <p>5/20/2025 157 lbs.</p> <p>5/13/2025 159 lbs.</p> <p>5/6/2025 159 lbs.</p> <p>5/1/2025 164 lbs.</p> <p>4/23/2025 164 lbs.</p> <p>4/23/2025 164 lbs.</p> <p>4/13/2025 171 lbs.</p> <p>4/1/2025 170 lbs.</p> <p>3/18/2025 167 lbs.</p> <p>3/7/2025 167 lbs.</p> <p>3/3/2025 167 lbs.</p> <p>3/3/2025 173 lbs.</p> <p>2/2/2025 180 lbs.</p> <p>1/1/2025 176 lbs.</p> <p>12/5/2024 179 lbs.</p> <p>12/1/2024 183 lbs.</p> <p>During a review of Resident 70 ' s Nutritional Assessment (NA)- Registered Dietician (RD), dated 6/15/2025, the NA indicated the resident was high risk for excessive weight loss and was recommended to have sugar free ice cream with lunch and dinner for weight management and to continue to monitor and follow up if needed (PRN).</p> <p>During a review of Resident 70 ' s IDT- Weight Management Care Plan (WCP), dated 6/16/2025, the WCP indicated the resident had recent weight loss, and was on diabetic (DM) snack, Glucerna shake, Vit C, multivitamins (MVI), and Zinc. The WCP indicated Resident 70 ' s recent weight taken on 6/1/2025 was 158 lbs., the resident ' s ideal body weight (IBW, the weight that is associated with the lowest risk of health problems for a person's height and build) range is 133 to 163 lbs. The WCP indicated the current weight is within IBW, RD was informed of the recent weight loss, and the IDT determined the weight loss may be due to fluid shifts, hospitalizations, medical diagnosis, and therapeutic diet. The WCP indicated to add Glucerna qd for 1 month.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 70 ' s Medication Administration Record (MAR) for 6/2025, the MAR indicated an order for Glucerna shake one time a day for weight management, for 1 month give at medication pass with an order date of 5/12/2025. The Glucerna was recommended by the IDT team to be resumed on readmission.</p> <p>During a review of Resident 70 ' s Care Plan (CP) Report titled, Resident has alteration in nutritional status, last revised on 6/4/2025, the CP indicated an intervention to provide supplements as ordered.</p> <p>During a concurrent interview and record review on 6/18/2025, at 9:20 a.m., with Registered Nurse (RN) 1, Reviewed Resident 70 ' s Medical Diagnosis, Order Summary Report, Weights and Vitals Summary, Nutritional Assessment- RD, IDT- Weight Management Care Plan, Medication Administration Record (MAR) for 6/2025, and Care Plans. RN 1 stated the IDT team were aware of the Resident 70 ' s weight loss, the IDT had met regularly to discuss the issue of resident ' s weight loss, and the RD had assessed the resident. RN 1 stated there was a recommendation from the IDT- Weight Management Care Plan on 6/16/2025 to give Glucerna 1 can qd to the resident for 30 days however, it was not carried out by the Assistant Director of Nursing (ADON) who attended the IDT.</p> <p>During a concurrent interview and record review on 6/18/2025, at 9:40 a.m., with the ADON, reviewed Resident 70 ' s IDT- Weight Management Care Plan on 6/16/2025, and the MAR for 6/2025. The ADON stated there was a recommendation from the IDT to give Glucerna 1 can qd for 30 days and she was not able to obtain an order from the physician. The ADON stated Resident 70 had been taking the Glucerna since admission, but she was not able to get an order to resume the supplement. The ADON stated the MAR still had the previous order dated of 5/12/2025 and Resident 70 had not been taking the Glucerna for 5 days now. The ADON stated she should have obtained an order from the physician to resume the Glucerna to prevent further weight loss of Resident 70.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the Director of Nursing (DON), the DON stated it was the responsibility of the ADON to ensure the recommendation of the IDT- Weight Management Team were followed to prevent Resident 70 ' s continued weight loss.</p> <p>During an interview on 6/20/2025, at 2:34 p.m., with the Dietary Consultant (DC), the DC stated she was aware of Resident 70 ' s continued weight loss and they were constantly monitoring the resident to prevent further loss. The DC stated she was aware of the IDT- Weight Management Care Plan on 6/16/2025, that the resident needed to have Glucerna 1 can qd for 30 days. The DC stated the licensed nurses should have obtained an order for the Glucerna upon the recommendation of the IDT- Weight Management Team to prevent further decline on Resident 70 ' s weight. The DC stated Resident 70 ' s weight is still within the resident ' s IBW.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled Weight Assessment and Intervention, last reviewed on 7/2024, the P&P indicated interventions for undesirable weight loss are based on careful consideration of the following:</p> <p>b. Nutrition and hydration needs of the resident.</p>		

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 06/20/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of five sampled residents (Resident 33) reviewed during the Medication Administration task, by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Licensed Vocational Nurse (LVN) 3 administered medication per facility policy and procedure (P&P) within one hour of the scheduled time. 2. Ensure LVN 3 documented the administration of medication per facility P&P at the time of administration in the resident ' s medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). <p>These deficient practices had the potential to result in adverse reactions (unwanted, uncomfortable, or dangerous effects that a drug may have) from the early administration of medication and miscommunication among caregivers.</p> <p>Cross Reference to F759 and F842.</p> <p>Findings:</p> <p>During a review of Resident 33 ' s admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2015 and most recently admitted the resident on 4/17/2025 with diagnoses that included sepsis (a life-threatening blood infection), acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in your body tissues), paranoid schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and hypertensive chronic kidney disease (kidney damage caused by hypertension [HTN, high blood pressure]).</p> <p>During a review of Resident 33 ' s Minimum Data Set (MDS &ndash; resident assessment tool) dated 4/22/2025, the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated Resident 33 required partial/moderate assistance from staff for dressing, oral hygiene, and toileting; and the resident required substantial / maximal assistance from staff for mobility.</p> <p>During a review of Resident 33 ' s Order Summary Report, the Order Summary Report indicated the following orders:</p> <ol style="list-style-type: none"> 1. Divalproex sodium (a medication to treat conditions related to mood regulation and the nervous system) sprinkles oral capsule, delayed release, 125 milligrams (mg, a unit of measurement), give 250 mg by mouth three times a day for schizoaffective disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily living activities, dated 4/22/2025. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Apixaban (a medication to help prevent blood clots [clumps that occur when blood hardens from a liquid to a solid]), oral tablet 2.5 mg, give 2.5 mg orally two times a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis, dated 4/17/2025.</p> <p>3. Olanzapine (a medication to treat mood disorders) oral tablet 7.5 mg, give 7.5 mg by mouth two times a day for schizoaffective disorder manifested by yelling at staff without apparent reason, dated 6/6/2025.</p> <p>4. Metoprolol succinate (a medication to treat high blood pressure), give 75 mg by mouth one time a day for HTN, give with food, dated 5/8/2025.</p> <p>During a review of Resident 33 ' s Care Plan (CP) regarding olanzapine, initiated 11/1/2024 and last revised 6/6/2025, the CP indicated an intervention to administer medication as per physician ' s order.</p> <p>During a review of Resident 33 ' s CP regarding divalproex sodium, initiated 11/1/2024 and last updated on 4/18/2025, the CP indicated an intervention to administer medication as ordered.</p> <p>During an interview on 6/18/2025 at 7:24 a.m., with LVN 3, LVN 3 stated Resident 33 had medications due at 7:30 a.m.</p> <p>During a concurrent medication pass observation and interview on 6/18/2025 at 7:30 a.m., with LVN 3 at the Station 1 Medication Cart, LVN 3 prepared and administered the following medications to Resident 33:</p> <ol style="list-style-type: none"> 1. Three 25 mg tablets of metoprolol succinate 2. Two capsules of 125mg divalproex sodium 3. One 2.5 mg tablet of apixaban 4. One 7.5 mg tablet of olanzapine <p>LVN 3 then exited Resident 33 ' s room and stated LVN 3 would document the administration of Resident 33 ' s administered medications. LVN 3 again stated that Resident 33 ' s medications were due at 7:30 a.m.</p> <p>During an interview on 6/18/2025 at 10:16 a.m. with the Infection Preventionist (IP), the IP stated the daily, routine a.m. medication pass is 9 a.m. The IP stated 9 a.m. medications may be administered up to one hour before and one hour after 9 a.m. The IP stated 9 a.m. medications should not be given prior to 8 a.m. The IP stated some resident medications are scheduled for an earlier pass time because those medications are administered with food.</p> <p>During an interview on 6/18/2025 at 10:30 a.m., with LVN 3, LVN 3 stated all the medications LVN 3 administered to Resident 33 on 6/18/2025 at 7:30 a.m. were due at 7:30 a.m. because the medications needed to be given with food.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/18/2025 at 10:43 a.m., with Registered Nurse (RN) 1, RN 1 reviewed Resident 33 ' s physician orders and Progress Notes for 6/2025. RN 1 stated the process for medication administration is to give medications within one hour of the prescribed time. RN 1 stated for medications that are prescribed to be administered twice a day and three times a day, the a.m. dose is routinely scheduled to be administered at 9 a.m. RN 1 reviewed Resident 33 ' s physician orders and progress notes and noted the following for the a.m. medications administered by LVN 3 on 6/18/2025:</p> <ul style="list-style-type: none"> - Divalproex sodium was scheduled to be administered at 9 a.m. When LVN 3 administered divalproex sodium at 7:30 a.m. it was given at the wrong time because divalproex sodium was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered divalproex sodium to Resident 33 early at 7:30 a.m. - Apixaban was scheduled to be administered at 9 a.m. When LVN 3 administered apixaban at 7:30 a.m. it was given at the wrong time because apixaban was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered apixaban to Resident 33 early at 7:30 a.m. - Olanzapine was scheduled to be administered at 9 a.m. When LVN 3 administered olanzapine at 7:30 a.m. it was given at the wrong time because olanzapine was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered olanzapine to Resident 33 early at 7:30 a.m. - Metoprolol was schedule to be administered at 7:30 a.m. and LVN 3 administered it at the correct time. <p>During an interview on 6/18/2025 at 11:10 a.m. with LVN 3 while in the presence of RN 1, LVN 3 stated in general medications need to be administered at the scheduled time. LVN 3 stated Resident 33 ' s olanzapine, apixaban, and divalproex sodium were due at 9 a.m., and 8 a.m. was the earliest time the medications should be administered. LVN 3 stated LVN 3 did not administer Resident 33 ' s olanzapine, apixaban, and divalproex sodium at the scheduled time. LVN 3 stated Resident 33 ' s olanzapine, apixaban, and divalproex sodium were administered early at 7:30 a.m. because LVN 3 prefers to give Resident 33 all the morning medications at the same time. LVN 3 stated Resident 33 is unpredictable and does not always want to take the medications when they are administered as scheduled at different times. LVN 3 stated LVN 3 did not document the administration of Resident 33 ' s olanzapine, apixaban, and divalproex sodium at 7:30 a.m. when the medications were administered. LVN 3 stated LVN 3 documented later in Resident 33 ' s MAR that olanzapine, apixaban, and divalproex sodium were administered during the scheduled time of 9 a. m. LVN 3 stated it was probably a medication error to administer Resident 33 ' s medications early.</p> <p>During a follow-up interview and record review on 6/18/2025 at 11:27 a.m. with RN 1, RN 1 reviewed the facility P&P regarding medication administration and documentation. RN 1 stated the facility policy is to administer medications within one hour of the scheduled time and LVN 3 did not follow the facility P&Ps when LVN 3 administered Resident 33 ' s medications early at 7:30 a.m. RN 1 stated medications must be documented in the MAR right after administration to a resident and prior to administering medications to the next resident to ensure the documentation is correct. RN 1 stated LVN 3 did not follow the facility process when LVN 3 did not document Resident 33 ' s medications at the time of administration and when LVN 3 did not document that the medications were given early.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/2025 at 12:26 p.m. with the Director of Nursing (DON), the DON stated it is important to administer medications at the correct time to ensure the amount of medication in the resident ' s body has the intended effect. The DON stated 9 a.m. medications should not be administered prior to 8 a.m. because the facility P&P indicates to administer medications within one hour of the scheduled time. The DON stated when LVN 3 administered Resident 33 ' s olanzapine, apixaban, and divalproex sodium at 7:30 a.m., it was considered early administration. The DON stated LVN 3 did not follow the facility P&P when Resident 33 ' s medications were administered early.</p> <p>During a follow-up interview and record review on 6/20/2025 at 3 p.m. with the DON, the DON reviewed Resident 33 ' s Medication Administration Audit Report and the facility policy and procedures regarding medication administration. The DON stated nurses do not decide to adjust the time of medication administration without contacting the physician. The DON stated the facility process is when a nurse is aware that a resident wants their morning medications administered all together at the same time, it is the nurse ' s responsibility to contact the physician. The DON stated if the physician agrees, then the medication administration times will be adjusted to ensure personalized care for the resident. The DON stated when LVN 3 administered Resident 33 ' s medications early there was a potential that medications would be given too close together affecting the efficacy of the medication. The DON stated LVN 3 did not follow the facility P&P and there was a potential that the resident ' s behaviors would not be properly managed by the medications and that the resident ' s preferences would not be respected. The DON stated the facility process is to document the administration of medication in the MAR right after administering medications to ensure accurate documentation of the medication given. The DON reviewed the Medication Administration Audit Report and noted the following for Resident 33 ' s a.m. medication administration on 6/18/2025:</p> <ul style="list-style-type: none"> - Divalproex sodium was scheduled for 9 a.m., LVN 3 administered at 7:30 a.m., and LVN 3 documented the administration at 10:57 a.m. - Apixaban was scheduled for 9 a.m., LVN 3 administered at 7:30 a.m., and LVN 3 documented the administration at 10:57 a.m. - Olanzapine was scheduled for 9 a.m., LVN 3 administered at 7:30 a.m., and LVN 3 documented the administration at 10:57 a.m. <p>The DON stated LVN 3 did not follow the facility P&P when LVN 3 did not document the administration of Resident 33 ' s medication right after administration.</p> <p>During a review of the facility P&P titled, Administering Medications, last reviewed 7/2024, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <ul style="list-style-type: none"> a) enhancing optimal therapeutic effect of the medication. b) preventing potential medication or food interactions; and <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c) honoring resident choices and preferences, consistent with his or her care plan.</p> <p>Medication errors are documented and reported. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and document the reason. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered.</p> <p>During a review of the facility P&P titled, Adverse Consequences and Medication Errors, last reviewed 7/2024, the P&P indicated an adverse consequence refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. The staff and practitioner strive to minimize adverse consequences. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders. Examples of medications errors include administering at the wrong time. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.</p>		

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 06/20/2025
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)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on interview and record review, the facility failed to ensure that one of three sampled residents (Resident 96) was free from unnecessary medication when Resident 96 was being treated with an anticoagulant (a medication that prevents blood clots from forming or existing clots from getting larger) without being adequately monitored for adverse effects (an undesired effect of a drug or other type of treatment).</p> <p>This failure had the potential to result in Resident 96 developing an adverse effect, such as bleeding, from the use of an anticoagulant without the facility being aware.</p> <p>Findings:</p> <p>During a review of Resident 96 ' s admission Record, dated 6/20/2025, the admission Record indicated Resident 96 ' s diagnoses include cerebral vascular accident (when blood flow to the brain is blocked or there is sudden bleeding in the brain), diabetes mellitus (DM &ndash; a disease where the body is unable to properly control blood sugar levels), hypertension (high blood pressure), and major depressive disorder (a condition in which a person has persistent feelings of sadness, hopelessness, and a loss of interest in activities once enjoyed).</p> <p>During a review of Resident 96 ' s History and Physical (H&P), dated April 29, 2025, the H&P indicated that Resident 96 had a history of deep vein thrombosis (a condition in which a blood clot forms in a deep vein, usually located in the legs) and pulmonary embolism (a condition where a blood clot, usually from the leg, travels to the lungs and blocks a blood vessel).</p> <p>During a review of Resident 96 ' s Minimum Data Set (MDS &ndash; a resident assessment tool), dated 5/5/2025, the MDS indicated Resident 96 had difficulty communicating some words or finishing thoughts. The MDS indicated Resident 96 was dependent to needing substantial assistance on mobility and activities of daily living (ADLs &ndash; such as bathing, dressing and toileting a person performs daily).</p> <p>During a concurrent interview and record review on 6/20/2025 at 9:41 a.m. with Licensed Vocational Nurse (LVN) 7, Resident 96 ' s Order Summary Report, dated 6/20/2025, was reviewed. LVN 7 stated the Order Summary Report indicated a doctor ' s order for Apixaban (an anticoagulant medication) 10 mg (milligram &ndash; a unit of measurement) by mouth two times a day for DVT LE [deep vein thrombosis of lower extremity] for 7 Days, followed by 5 mg by mouth two times a day for DVT LE. LVN 7 stated the Order Summary Report did not indicate a doctor ' s order to monitor for adverse effects, such as bleeding, while being treated with Apixaban. LVN 7 stated bleeding is the main adverse effect when taking an anticoagulant medication. LVN 7 stated nurses can monitor for bleeding by performing a head-to-toe assessment (when a healthcare professional examines a resident ' s body, from head to feet, to check for overall health and well-being) and observing for any bluish-purple discoloration of the skin, such as bruises.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/20/2025 at 9:45 a.m. with LVN 7, Resident 96 ' s Care Plan and Medication Administration Record (MAR), both dated 6/20/2025, were reviewed. LVN 7 stated the Care Plan indicated Resident 96 was at risk for bleeding and bruising due to anticoagulant therapy. LVN 7 stated the Care Plan indicated that nurses are to assess for signs and symptoms of bleeding, such as blood in urine or stool and/or coffee ground emesis. LVN 7 stated Resident 96 ' s MAR did not have any indication that Resident 96 was being monitored for adverse effects, such as bleeding, while on anticoagulant therapy. LVN 7 stated, I don't see any documentation that nurses were monitoring for bleeding.</p> <p>During an interview and record review on 6/20/2025 at 1:15 p.m. with the Director of Nursing (DON), Resident 96 ' s Order Summary Report and MAR, both dated 6/20/2025, were reviewed. The DON stated Resident 96 had a doctor ' s order for Apixaban, which is an anticoagulant medication. The DON stated anticoagulant medications can cause bleeding, and it can place residents at an increased risk for bruising. The DON stated that the facility has an internal order to monitor for adverse effects, such as bleeding, while residents are on anticoagulant therapy. The DON stated the facility will enter that order by specifically typing into their computer system that nurses are to monitor for adverse effects, which is then reflected in a resident ' s MAR. The DON stated there was no indication in Resident 96 ' s MAR that nurses were to monitor for adverse effects, while Resident 96 was on anticoagulant therapy.</p> <p>During an interview on 6/20/2025 at 1:18 p.m. with the DON, the DON stated it is important to monitor Resident 96 for adverse effects while on anticoagulant therapy because the facility need[s] to identify possible bleeding. The DON stated that if bleeding is found, the facility need[s] to inform the doctor and need[s] to proceed with pharmacological interventions, such as stopping the administration of the anticoagulant medication immediately. The DON stated, it is considered an unnecessary mediation if bleeding is not [being] monitored.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, dated 7/2025, the P&P indicated: Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported.</p>		

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 06/20/2025
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (% - one part in every hundred). Three medication errors out of 25 total opportunities contributed to an overall medication error rate of 12% affecting one of five sampled residents observed for medication administration (Resident 33). Resident 33 did not receive divalproex sodium (a medication to treat conditions related to mood regulation and the nervous system), apixaban (a medication to help prevent blood clots [clumps that occur when blood hardens from a liquid to a solid]), and olanzapine (a medication to treat mood disorders) on 6/18/2025 at the prescribed time.</p> <p>These failures had the potential for Resident 33 to experience the medications ' adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) when not given at the prescribed time negatively impacting the resident ' s physical and mental health.</p> <p>Cross Reference F755</p> <p>Findings:</p> <p>During a review of Resident 33 ' s admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2015 and most recently admitted the resident on 4/17/2025 with diagnoses that included sepsis (a life-threatening blood infection), acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in your body tissues), paranoid schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and hypertensive chronic kidney disease (kidney damage caused by hypertension [HTN, high blood pressure]).</p> <p>During a review of Resident 33 ' s Minimum Data Set (MDS &ndash; resident assessment tool), dated 4/22/2025, the MDS indicated Resident 33 was able to understand others and was able to make themself understood. The MDS indicated Resident 33 required partial/moderate assistance from staff for dressing, oral hygiene, and toileting; and the resident required substantial / maximal assistance from staff for mobility.</p> <p>During a review of Resident 33 ' s Order Summary Report, the Order Summary Report indicated the following orders:</p> <ol style="list-style-type: none"> 1.Divalproex sodium sprinkles oral capsule, delayed release, 125 milligrams (mg, a unit of measurement), give 250 mg by mouth three times a day for schizoaffective disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily living activities, dated 4/22/2025. 2.Apixaban, oral tablet 2.5 mg, give 2.5 mg orally two times a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis, dated 4/17/2025. 3. Olanzapine oral tablet 7.5 mg, give 7.5 mg by mouth two times a day for schizoaffective disorder manifested by yelling at staff without apparent reason, dated 6/6/2025. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Metoprolol succinate (a medication to treat high blood pressure), give 75 mg by mouth one time a day for HTN, give with food, dated 5/8/2025.</p> <p>During a review of Resident 33 ' s Care Plan (CP) regarding olanzapine, initiated 11/1/2024 and last revised 6/6/2025, the CP indicated an intervention to administer medication as per physician ' s order.</p> <p>During a review of Resident 33 ' s CP regarding divalproex sodium, initiated 11/1/2024 and last updated on 4/18/2025, the CP indicated an intervention to administer medication as ordered.</p> <p>During an interview on 6/18/2025 at 7:24 a.m., with LVN 3, LVN 3 stated Resident 33 had medications due at 7:30 a.m.</p> <p>During a concurrent medication pass observation and interview on 6/18/2025 at 7:30 a.m., with LVN 3 at the Station 1 Medication Cart, LVN 3 prepared and administered the following medications to Resident 33:</p> <ol style="list-style-type: none"> 1. Three 25 mg tablets of metoprolol succinate 2. Two capsules of 125mg divalproex sodium 3. One 2.5 mg tablet of apixaban 4. One 7.5 mg tablet of olanzapine <p>LVN 3 then exited Resident 33 ' s room and stated LVN 3 would document the administration of Resident 33 ' s administered medications. LVN 3 again stated that Resident 33 ' s medications were due at 7:30 a.m.</p> <p>During an interview on 6/18/2025 at 10:16 a.m. with the Infection Preventionist (IP), the IP stated the daily, routine a.m. medication pass is 9 a.m. The IP stated 9 a.m. medications may be administered up to one hour before and one hour after 9 a.m. The IP stated 9 a.m. medications should not be given prior to 8 a.m. The IP stated some resident medications are scheduled for an earlier pass time because those medications are administered with food.</p> <p>During an interview on 6/18/2025 at 10:30 a.m., with LVN 3, LVN 3 stated all the medications LVN 3 administered to Resident 33 on 6/18/2025 at 7:30 a.m. were due at 7:30 a.m. because the medications needed to be given with food.</p> <p>During a concurrent interview and record review on 6/18/2025 at 10:43 a.m., with Registered Nurse (RN) 1, RN 1 reviewed Resident 33 ' s physician orders and Progress Notes for 6/2025. RN 1 stated the process for medication administration is to give medications within one hour of the prescribed time. RN 1 stated for medications that are prescribed to be administered twice a day and three times a day, the a.m. dose is routinely scheduled to be administered at 9 a.m. RN 1 reviewed Resident 33 ' s physician orders and progress notes and noted the following for the a.m. medications administered on 6/18/2025:</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Divalproex sodium was scheduled to be administered at 9 a.m. When LVN 3 administered divalproex sodium at 7:30 a.m. it was given at the wrong time because divalproex sodium was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered divalproex sodium to Resident 33 early at 7:30 a.m.</p> <p>- Apixaban was scheduled to be administered at 9 a.m. When LVN 3 administered apixaban at 7:30 a.m. it was given at the wrong time because apixaban was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered apixaban to Resident 33 early at 7:30 a.m.</p> <p>- Olanzapine was scheduled to be administered at 9 a.m. When LVN 3 administered olanzapine at 7:30 a.m. it was given at the wrong time because olanzapine was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered olanzapine to Resident 33 early at 7:30 a.m.</p> <p>- Metoprolol was schedule to be administered at 7:30 a.m. and LVN 3 administered and documented it at the correct time.</p> <p>During an interview on 6/18/2025 at 11:10 a.m. with LVN 3 while in the presence of RN 1, LVN 3 stated in general medications need to be administered at the scheduled time. LVN 3 stated Resident 33 ' s olanzapine, apixaban, and divalproex sodium were due at 9 a.m., and 8 a.m. was the earliest time the medications should be administered. LVN 3 stated LVN 3 did not administer Resident 33 ' s olanzapine, apixaban, and divalproex sodium at the scheduled time. LVN 3 stated Resident 33 ' s olanzapine, apixaban, and divalproex sodium were administered early at 7:30 a.m. because LVN 3 prefers to give Resident 33 all the morning medications at the same time. LVN 3 stated Resident 33 is unpredictable and does not always want to take the medications when they are administered as scheduled at different times. LVN 3 stated LVN 3 did not document the administration of Resident 33 ' s olanzapine, apixaban, and divalproex sodium at 7:30 a.m. when the medications were administered. LVN 3 stated LVN 3 documented later in Resident 33 ' s MAR that olanzapine, apixaban, and divalproex sodium were administered during the scheduled time of 9 a.m. LVN 3 stated it was probably a medication error to administer Resident 33 ' s medications early.</p> <p>During a follow-up interview and record review on 6/18/2025 at 11:27 a.m. with RN 1, RN 1 reviewed the facility P&P regarding medication administration and documentation. RN 1 stated the facility policy is to administer medications within one hour of the scheduled time and LVN 3 did not follow the facility P&Ps when LVN 3 administered Resident 33 ' s medications early at 7:30 a.m. RN 1 stated medications must be documented in the MAR right after administration to a resident and prior to administering medications to the next resident to ensure the documentation is correct. RN 1 stated LVN 3 did not follow the facility process when LVN 3 did not document Resident 33 ' s medications at the time of administration and when LVN 3 did not document that the medications were given early.</p> <p>During an interview on 6/18/2025 at 12:26 p.m. with the Director of Nursing (DON), the DON stated it is important to administer medications at the correct time to ensure the amount of medication in the resident ' s body has the intended effect. The DON stated 9 a.m. medications should not be administered prior to 8 a.m. because the facility P&P indicates to administer medications within one hour of the scheduled time. The DON stated when LVN 3 administered Resident 33 ' s olanzapine, apixaban, and divalproex sodium at 7:30 a.m., it was considered early administration. The DON stated LVN 3 did not follow the facility P&P when Resident 33 ' s medications were administered early.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a follow-up interview and record review on 6/20/2025 at 3 p.m. with the DON, the DON stated nurses do not decide to adjust the time of medication administration without contacting the physician. The DON stated the facility process is when a nurse is aware that a resident wants their morning medications administered all together at the same time, it is the nurse ' s responsibility to contact the physician. The DON stated if the physician agrees, then the medication administration times will be adjusted to ensure personalized care for the resident. The DON stated when LVN 3 administered Resident 33 ' s medications early there was a potential that medications would be given too close together affecting the efficacy of the medication. The DON stated LVN 3 did not follow the facility P&P and there was a potential that the resident ' s behaviors would not be properly managed by the medications and that the resident ' s preferences would not be respected.</p> <p>During a review of the facility P&P titled, Administering Medications, last reviewed 7/2024, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <ul style="list-style-type: none"> a) enhancing optimal therapeutic effect of the medication. b) preventing potential medication or food interactions; and c) honoring resident choices and preferences, consistent with his or her care plan. <p>Medication errors are documented and reported. Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and document the reason. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered.</p> <p>During a review of the facility P&P titled, Adverse Consequences and Medication Errors, last reviewed 7/2024, the P&P indicated an adverse consequence refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. The staff and practitioner strive to minimize adverse consequences. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders. Examples of medications errors include administering at the wrong time. The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis.</p>		

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 06/20/2025
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to rotate (a method to ensure repeated injections are not administered in the same area) insulin (a hormone that lowers the level of sugar in the blood) injection sites each time insulin was administered for one of three sampled residents (Resident 96).</p> <p>This failure resulted in a significant medication error when multiple nurses repeatedly failed to rotate insulin injection sites during the administration of insulin to Resident 96 in 4/2025 and 5/2025.</p> <p>Findings:</p> <p>During a review of Resident 96 ' s admission Record, dated 6/20/2025, the admission Record indicated Resident 96 ' s diagnoses include cerebral vascular accident (when blood flow to the brain is blocked or there is sudden bleeding in the brain), diabetes mellitus (DM &ndash; a disease where the body is unable to properly control blood sugar levels), hypertension (high blood pressure), and major depressive disorder (a condition in which a person has persistent feelings of sadness, hopelessness, and a loss of interest in activities once enjoyed).</p> <p>During a review of Resident 96 ' s Minimum Data Set (MDS &ndash; a resident assessment tool), dated 5/5/2025, the MDS indicated Resident 96 had difficulty communicating some words or finishing thoughts. The MDS indicated Resident 96 was dependent to needing substantial assistance on mobility and activities of daily living (ADLs &ndash; such as bathing, dressing and toileting a person performs daily).</p> <p>During a concurrent interview and record review on 6/20/2025 at 9:55 a.m. with LVN 7, Resident 96 ' s Order Summary Report, dated 6/20/2025, was reviewed. LVN 7 stated the Order Summary Report indicated that regular insulin is to be injected subcutaneously (the area located just beneath the skin) before meals and at bedtime to treat Resident 96 ' s DM, and to rotate injection sites each time an injection is given. LVN 7 stated the Order Summary Report also indicated insulin glargine solution is to be injected subcutaneously at bedtime depending on Resident 96 ' s blood sugar level, and to rotate injection sites.</p> <p>During a concurrent interview and record review on 6/20/2025 at 9:59 a.m. with LVN 7, Resident 96 ' s Location of Administration Report, for the month of 4/2025 and 5/2025, were reviewed. LVN 7 stated the facility failed to rotate the injection sites when giving insulin injections to Resident 96 on the following dates: 4/18/2025, 4/19/2025, 4/20/2025, 4/21/2025, 4/22/2025, 5/3/2025, 5/4/2025, 5/5/2025, and 5/31/2025. LVN 7 stated the failure to rotate insulin injection sites was performed by multiple, different nurses. LVN 7 stated injecting repeatedly at the same site of the body can make the skin thicker at the injection site, which prevents insulin from being absorbed properly.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/20/2025 at 1:04 p.m. with the DON, Resident 96 ' s Location of Administration Report, for the month of 4/2025 and 5/2025 were reviewed. The DON stated the facility failed to rotate the injection sites when giving insulin injections to Resident 96 on the following dates: 4/18/2025, 4/19/2025, 4/20/2025, 4/21/2025, 4/22/2025, 5/3/2025, 5/4/2025, 5/5/2025, and 5/31/2025. The DON stated insulin injections may be given in fatty areas of the body such as the abdomen, upper extremities, and anterior portion of the thighs. The DON stated nurses must rotate the injection sites when giving insulin injections to avoid lipohypertrophy, which is a complication resulting in thicker skin that affects the absorption of insulin by the body.</p> <p>During an interview on 6/20/2025 at 1:10 p.m. with the Director of Nursing (DON), the DON stated rotating insulin injection sites is part of licensed nursing professional practice. The DON stated multiple nurses failed to rotate the insulin injections sites when administering insulin to Resident 96 in the months of 4/2025 and 5/2025. The DON stated that if nurses are failing to rotate insulin injections sites, then it means [the facility is] not administering the prescribed medication per the doctor's orders. The DON stated manufacturing specifications for insulin will specify that the insulin administration must be rotated to avoid adverse effects. The DON stated that repeatedly failing to rotate injection sites is a significant medication error because the facility did not follow the doctor ' s orders, professional practice, and manufacturing specifications.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Insulin Administration, dated 7/2024, the P&P indicated: Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).</p> <p>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, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. The P&P also indicated that staff and practitioner shall strive to minimize adverse consequences resulting from medication errors by following relevant clinical guidelines and manufacturer ' s specifications.</p>		

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 06/20/2025
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen reviewed during the Kitchen task by failing to:</p> <ol style="list-style-type: none"> 1. Ensure food items in Refrigerator 1, the Walk-in Refrigerator, and the Walk-in Freezer were labeled according to facility policy. 2. Ensure kitchen areas were cleaned and sanitized when the Walk-in Freezer floor had sticky, discolored ice buildup and the Dry Food Storage Area had spilled dry cereal. 3. Ensure five dented cans were not found with non-dented cans in the Dry Food Storage Area. <p>These deficient practices had the potential to result in harmful bacterial growth and cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 122 of 124 medically compromised residents who received food and ice from the kitchen.</p> <p>Findings:</p> <p>a. During an Initial Kitchen Tour on 6/16/2025 at 7:50 a.m., with the Dietary Supervisor (DS), [NAME] 1, and Registered Dietician (RD) 1, observed Refrigerator 1, the Walk-in Refrigerator, and the Walk-in Freezer. [NAME] 1 stated the facility process is all food items, including items that are removed from the original packaging or are prepared by staff, are labeled with the item contents and the date prepared or opened. [NAME] 1 stated all food items are labeled to know what foods are being served to residents and to ensure no expired foods are served.</p> <p>RD 1 and [NAME] 1 noted the following in Refrigerator 1:</p> <ul style="list-style-type: none"> - [NAME] 1 noted there was an unlabeled clear plastic pitcher of white liquid. [NAME] 1 stated [NAME] 1 thought the pitcher contained thickened milk. [NAME] 1 stated the evening kitchen staff placed the unlabeled pitcher in the refrigerator without labeling it. [NAME] 1 stated [NAME] 1 would throw out the liquid because it was not labeled. - [NAME] 1 noted there was an opened container of yogurt, and an opened container of creamer not labeled with the date opened. [NAME] 1 stated the expiration date of the yogurt and creamer changes once the containers have been opened, so it is important to know when the yogurt and creamer were opened to ensure expired foods were not served to residents. [NAME] 1 stated [NAME] 1 did not know the open date of the yogurt or creamer. - [NAME] 1 noted there was an unlabeled pan of thick sauce. [NAME] 1 stated [NAME] 1 placed the pan of apple sauce in the Refrigerator 1 that morning and did not label the apple sauce. [NAME] 1 stated [NAME] 1 should have labeled the pans contents and the date of preparation prior to placing the pan in Refrigerator 1 but [NAME] 1 did not. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- RD 1 noted there was a clear plastic container of cut up lettuce and shredded carrots labeled Jelly 6-10-25. RD 1 stated the container was mislabeled and the container clearly did not have jelly in it. RD 1 stated the salad should be thrown out because the label did not match the contents and there was no way to know when the salad was prepared.</p> <p>The DS noted the following in the Walk-in Refrigerator:</p> <p>- There was a pan of light brown food substance labeled diet, 6/16/25. The DS stated the food was probably sugar free cake mix, but the DS was not sure because the food contents were not labeled. The DS stated all food items need to be labeled to indicate what the food is because the kitchen staff needs to know exactly what they are serving to resident. The DS stated some residents have food allergies and staff must ensure these foods are not served to residents because an allergic reaction may cause harm to a resident.</p> <p>- There was an unlabeled clear plastic bottle of a white sauce. The DS stated the bottle was possibly tartar sauce or ranch dressing, but the DS was not sure because it was not labeled with the contents. The DS stated any time food is removed from the original container to a new container, the new container must be labeled with the contents and date of preparation to ensure expired foods are not served to resident potentially causing illness in residents.</p> <p>The DS noted the following in the Walk-in Freezer:</p> <p>- There was an opened and unlabeled bag of possible frozen meatballs and one opened bag of possible frozen waffles. The DS stated the meatballs and waffles were not labeled with the item contents, date opened, or expiration date when they were removed from the original boxes, but they should have been. The DS stated labeling the contents and dates ensures expired food is not served, the contents are known, and the the first in first out method (FIFO, an inventory management method where the oldest inventory items are used first) was followed.</p> <p>During a concurrent interview and record review on 06/20/2025 at 11:36 a.m., RD 1 reviewed the facility policy and procedure (P&P) regarding food storage and labeling. RD 1 stated many residents cannot eat every type of food and may be limited by allergies, food preferences, and food textures. RD 1 stated food labeling is important to identify products to ensure the correct product is used and served to residents. RD 1 stated when the wrong textured food is served to residents it may cause aspiration and harm from choking. RD 1 stated if the wrong food is served to a resident that has allergens, then the resident may have an allergic reaction. RD 1 stated the kitchen staff did not follow the facility policy for labeling of food contents. RD 1 stated the facility kitchen follows the USDA guidelines for food storage, so the open or prepared date is important to determine when the food should be discarded. RD 1 stated when the kitchen staff did not label the open date on the food, there was a potential that expired potentially hazardous food would be served causing food borne illnesses in residents. RD 1 stated the kitchen staff did not follow the facility policy for labeling of open and prepared dates on food.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the P&P titled, Refrigerator / Freezer Storage, last reviewed 7/2024, the P&P indicated leftover food or unused portions of packaged foods should be covered, dated and labeled to ensure they will be used first. All items should be properly covered, dated, and labeled. Food items should have the following appropriate dates: delivery date - upon receipt, open date - opened containers of potentially hazardous food, and thaw date - any frozen items. Frozen food taken from the original packaging should be labeled and dated. Leftovers will be covered, dated, labeled, and discarded within 72 hours. Older food items should be rotated using the FIFO method (First-in First-out). No food item that is expired or beyond the best buy date are in stock. Dry goods storage guidelines and Refrigerator and freezer storage chart to be followed unless manufacture recommendation showing it can be kept longer.</p> <p>During a review of the facility provided Dry Goods Storage Guidelines, dated 2018, the Dry Goods Storage Guidelines indicated the following storage length is to be followed unless there are manufacture recommendations showing a different length of time:</p> <ul style="list-style-type: none"> - Applesauce: one week when open in refrigerator - Salad dressing, made from mix: two weeks when open in refrigerator - Salad dressing, bottled: two months when open in refrigerator - Sauces, bottled: one year when open in refrigerator. - Creamer: opened, six months. - Condensed and evaporated milk: four days. <p>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) & (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture ' s use-by- date if the manufacturer determined the use-by date based on food safety.</p> <p>b.1. During an Initial Kitchen Tour on 6/16/2025 at 7:50 a.m., with the DS, observed the Walk-in Freezer. Observed sticky, dirty ice buildup on the floor of the freezer at the entrance. The DS stated the ice buildup was a safety hazard and not sanitary.</p> <p>During a follow up Kitchen Tour on 6/17/2025 at 11:45 a.m., with RD 2, observed the Walk-in Freezer. Observed sticky, dirty ice buildup on the floor of the freezer at the entrance. RD 2 stated the ice build up was beige colored and should not be in the freezer. RD 2 stated the Walk-in Freezer floor should have been cleaned on 6/16/2025 and it was not.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 06/20/2025 at 11:36 a.m., RD 1 reviewed the facility P&P regarding freezer storage and kitchen cleaning. RD 1 stated the Walk-in Freezer had an identified issue that was not compromising the stored food. RD 1 stated the freezer issue caused ice build up on the freezer floor that should be cleaned daily, but the kitchen staff did not clean the freezer floor on 6/16/2025. RD 1 stated kitchen surfaces, including freezer floors, should not have dirt and ice buildup for safety and sanitation purposes. RD 1 stated when kitchens are not clean there is a possibility for cross contamination. RD 1 stated the facility P&Ps were not followed when the Walk in Freezer had ice build up on the floor.</p> <p>During a review of the P&P titled, Refrigerator / Freezer Storage, last reviewed 7/2024, the P&P indicated the refrigerator and freezer area will be clean, dry, and well-ventilated at all times.</p> <p>During a review of the P&P titled, Cleaning Schedule, last reviewed 7/2024, the P&P indicated all areas and equipment in the kitchen should be cleaned daily.</p> <p>During a review of the P&P titled, Sanitizing Equipment and Surfaces, last reviewed 7/2024, the P&P indicated sanitizing solution will be used to sanitize equipment and surfaces after each use or as often as needed. Dietary staff should ensure that all equipment, shelves, serving utensils, and surface areas are clean and in good condition.</p> <p>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues.</p> <p>b.2. During an Initial Kitchen Tour on 6/16/2025 at 7:50 a.m., with the DS and RD 2, observed the Dry Food Storage Area. The DS stated there was spilled, dry cereal on top of canned food and plastic bins. RD 2 stated the spill must have just occurred during the delivery service, but it would be cleaned. The DS stated spilled cereal should be cleaned when the spill occurs to prevent attracting pests and rodents to the Dry Food Storage Area. The DS stated it was not sanitary to have pests or rodents in the Dry Food Storage Area.</p> <p>During a follow-up Kitchen Tour on 6/17/2025 at 11:45 a.m., with RD 2, observed the Dry Food Storage Area. Observed spilled dry cereal remained on a plastic bin. RD 2 stated spilled dry cereal should not be in the Dry Food Storage Area for cleanliness because the cereal could attract pests.</p> <p>During a concurrent interview and record review on 06/20/2025 at 11:36 a.m., RD 1 reviewed the facility P&P regarding storage of canned and dry goods and sanitation and cleanliness. RD 1 stated food left out can attract disease carrying pests that can contaminate the food and cause cross contamination resulting in food borne illness in residents. RD 1 stated the facility P&P was not followed when spilled dry cereal was in the Dry Food Storage Area.</p> <p>During a review of the P&P titled, Storage of Canned and Dry Goods, last reviewed 7/2024, the P&P indicated food and supplies will be stored properly and in a safe manner. The storage area will be clean, dry, and well-ventilated at all times. Remove food from packaging boxes upon delivery to minimize pests. Loose items like cookies, crackers, sugar packets, etc. should be placed in containers or bins. Storage area will be cleaned regularly and checked for any evidence of pests.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Food Code 2017, indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301-3-306.</p> <p>c. During an Initial Kitchen Tour on 6/16/2025 at 7:50 a.m., with the DS and RD 2, observed the Dry Food Storage Area. RD 2 stated the facility was currently receiving a delivery of canned and dry foods. RD 2 stated food should never be served from dented cans. RD 2 stated the facility process is as stock is delivered, staff removes dented cans from the shelves and places the dented cans in a dented can bin. Observe bin labeled Dented Cans. RD 2 stated there was a dented can of tuna that remained on the canned food storage shelf and staff would remove the can as they stock the shelves on 6/16/2025.</p> <p>During a follow-up Kitchen Tour on 6/17/2025 at 11:45 a.m., with RD 2, observed the Dry Food Storage Area. RD 2 stated it was important to remove dented cans from the canned food storage shelves because a dented food can may have bacterial growth that could cause illness if the food is served to residents. RD 2 stated the Dry Food Storage Area was organized and looked much better after the delivery on 6/16/2025. RD 2 stated staff had removed the dented tuna can from the canned foods shelf to the dented can bin and no other dented cans should remain on the canned food shelf. RD 2 observed the canned food storage shelves and noted the following:</p> <ul style="list-style-type: none"> - There were two dented cans of mandarin oranges. - There was one dented can of sliced apples. - There were two dented cans of Chile Verde sauce. <p>RD 2 then stated the kitchen staff should have removed the dented cans, but they did not.</p> <p>During a concurrent interview and record review on 06/20/2025 at 11:36 a.m., RD 1 reviewed the facility P&P regarding storage of canned and dry goods. RD 1 stated food from dented cans is not served in the facility because there is a potential for food borne illness. RD 1 stated any dented cans are separated and returned to the distributor for re-imburement. RD 1 stated dented cans are usually identified during delivery, but cans need to be inspected when on the shelves. RD 1 stated the facility P&P was not followed when dented cans were on the canned food storage shelves.</p> <p>During a review of the P&P titled, Storage of Canned and Dry Goods, last reviewed 7/2024, the P&P indicated food and supplies will be stored properly and in a safe manner. Canned items should be inspected for damage such as dented, leaking or bulging cans. These items will be stored separately in the designated area - DENTED CANS for return to the vendor or disposed of properly.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of §3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fall victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard.</p>

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** d. During a record review of Resident 116 ' s admission Record, the admission Record indicated the facility admitted Resident 116 on 10/15/2024, with diagnoses that included unspecified (unconfirmed) cerebrovascular disease (a group of conditions that affect blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia (reduced blood flow to the brain, which damages brain tissue and impairs cognitive functions).</p> <p>During a review of Resident 116 ' s History and Physical Examination (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings) Visit, dated 10/15/2024, the H&P indicated Resident 116 was alert and needed visual cues (non-verbal signals that provide information, guide actions, or enhance understanding through visual elements).</p> <p>During a review of Resident 116 ' s Advance Healthcare Directive Acknowledgment, dated 10/15/2024, the Advance Healthcare Directive Acknowledgment indicated Resident 116 did not execute an Advance Directive.</p> <p>During a review of Resident 116 ' s Psycho-Social Assessment, dated 10/16/2024, the Psycho-Social Assessment indicated Resident 116 had an Advance Directive.</p> <p>During a review of Resident 116 ' s Minimum Data Set (MDS-a resident assessment tool), dated 5/16/2025, the MDS indicated Resident 116 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired.</p> <p>During a concurrent interview, and record review on 6/18/2025, at 6:32 a.m., with the Social Service Director 1 (SSD 1), Resident 116 Advance Healthcare Directive Acknowledgment, dated 10/15/2024 and Psycho-Social Assessment, dated 10/16/2024, were reviewed. SSD 1 stated previous SSD 2 documentation was inaccurate. SSD 1 stated Resident 116 did not have an Advance Directive.</p> <p>During an interview on 6/18/2025, at 1:17 p.m., with the DON, the DON stated because of two different answers on Advance Directive, Resident 116 ' s medical record created a confusion whether Resident 116 had or did not have an Advance Directive.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the DON, facility ' s policy and procedure (P&P) titled, Charting and Documentation dated 7/2017, and last reviewed on 7/2024, the P&P indicated, All services provided to the resident, progress toward the care plan goals or any changes in the resident's medical, physical, functional or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT- a coordinated group of experts from several different fields who work together) regarding the resident ' s condition and response to care Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. The DON stated the facility ' s policy on charting indicated documentation should be accurate to prevent confusion in care.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility ' s P&P titled, Advance Directive, dated 9/2022, and last reviewed on 7/2024, the P&P indicated, Prior to or upon admission of a resident, the SSD or designee inquires of the resident, his/her family members and/or his or her legal representative about the existence of any written advance directives.</p> <p>Based on observation, interview, and record review, the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices for four of nine sampled residents (Residents 33, 70, 23, and 116) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Licensed Vocational Nurse (LVN) 3 accurately documented in the medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) the time of medication administration on 6/18/2025 for divalproex sodium (a medication to treat conditions related to mood regulation and the nervous system), apixaban (a medication to help prevent blood clots [clumps that occur when blood hardens from a liquid to a solid]), and olanzapine (a medication to treat mood disorders) for Resident 33 reviewed during the Medication Administration task. <p>This resulted in inaccurate documentation in Resident 33 ' s medical chart.</p> <ol style="list-style-type: none"> 2. Ensure Informed Consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for Risperdal (is a medication primarily used to help people with certain mental health conditions) and Trileptal (a medication that helps calm down overactive electrical activity in your brain that causes seizures) was signed and dated by the physician for Resident 70. 3. Ensure Informed Consent for Depakote (is a medication primarily used to help control certain conditions affecting the brain) had a date on the physician ' s signature and the box on how the Informed Consent was obtained was filled out by the verifying nurse for Resident 23. <p>These deficient practices had the potential to negatively impact the delivery of services to Residents 70 and 23.</p> <ol style="list-style-type: none"> 4. Ensure the Advance Directive (a legal document indicating resident preference on end-of-life treatment decisions) was accurately documented for Resident 116. <p>This failure had the potential to cause confusion in Resident 116 ' s care and the medical records containing inaccurate documentation.</p> <p>Cross reference to F755.</p> <p>Findings: (continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. During a review of Resident 33 ' s admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2015 and most recently admitted the resident on 4/17/2025 with diagnoses that included sepsis (a life-threatening blood infection), acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in your body tissues), paranoid schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and hypertensive chronic kidney disease (kidney damage caused by hypertension [HTN, high blood pressure]).</p> <p>During a review of Resident 33 ' s Minimum Data Set (MDS &ndash; resident assessment tool) dated 4/22/2025, the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated that the resident required partial/moderate assistance from staff for dressing, oral hygiene, and toileting; and the resident required substantial / maximal assistance from staff for mobility.</p> <p>During a review of Resident 33 ' s Order Summary Report, the Order Summary Report indicated the following orders:</p> <ol style="list-style-type: none"> 1. Divalproex sodium sprinkles oral capsule, delayed release, 125 milligrams (mg, a unit of measurement), give 250 mg by mouth three times a day for schizoaffective disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily living activities, dated 4/22/2025. 2. Apixaban, oral tablet 2.5 mg, give 2.5 mg orally two times a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis, dated 4/17/2025. 3. Olanzapine oral tablet 7.5 mg, give 7.5 mg by mouth two times a day for schizoaffective disorder manifested by yelling at staff without apparent reason, dated 6/6/2025. 4. Metoprolol succinate (a medication to treat high blood pressure), give 75 mg by mouth one time a day for HTN, give with food, dated 5/8/2025. <p>During an interview on 6/18/2025 at 7:24 a.m., with LVN 3, LVN 3 stated Resident 33 had medications due at 7:30 a.m.</p> <p>During a concurrent medication pass observation and interview on 6/18/2025 at 7:30 a.m., with LVN 3 at the Station 1 Medication Cart, LVN 3 prepared and administered the following medications to Resident 33:</p> <ol style="list-style-type: none"> 1. Three 25 mg tablets of metoprolol succinate 2. Two capsules of 125mg divalproex sodium 3. One 2.5 mg tablet of apixaban 4. One 7.5 mg tablet of olanzapine <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>LVN 3 then exited Resident 33 ' s room and stated LVN 3 would document the administration of Resident 33 ' s administered medications. LVN 3 again stated that Resident 33 ' s medications were due at 7:30 a.m.</p> <p>During an interview on 6/18/2025 at 10:16 a.m. with the Infection Preventionist (IP), the IP stated the daily, routine a.m. medication pass is 9 a.m. The IP stated 9 a.m. medications may be administered up to one hour before and one hour after 9 a.m. The IP stated 9 a.m. medications should not be given prior to 8 a.m. The IP stated some resident medications are scheduled for an earlier pass time because those medications are administered with food.</p> <p>During an interview on 6/18/2025 at 10:30 a.m., with LVN 3, LVN 3 stated all the medications LVN 3 administered to Resident 33 on 6/18/2025 at 7:30 a.m. were due at 7:30 a.m. because the medications needed to be given with food.</p> <p>During a concurrent interview and record review on 6/18/2025 at 10:43 a.m., with Registered Nurse (RN) 1, RN 1 reviewed Resident 33 ' s physician orders and Progress Notes for 6/2025. RN 1 stated the process for medication administration is to give medications within one hour of the prescribed time. RN 1 stated for medications that are prescribed to be administered twice a day and three times a day, the a.m. dose is routinely scheduled to be administered at 9 a.m. RN 1 reviewed Resident 33 ' s physician orders and progress notes and noted the following for the a.m. medications administered by LVN 3 on 6/18/2025:</p> <ul style="list-style-type: none"> - Divalproex sodium was scheduled to be administered at 9 a.m. When LVN 3 administered divalproex sodium at 7:30 a.m. it was given at the wrong time because divalproex sodium was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered divalproex sodium to Resident 33 early at 7:30 a.m. - Apixaban was scheduled to be administered at 9 a.m. When LVN 3 administered apixaban at 7:30 a.m. it was given at the wrong time because apixaban was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered apixaban to Resident 33 early at 7:30 a.m. - Olanzapine was scheduled to be administered at 9 a.m. When LVN 3 administered olanzapine at 7:30 a.m. it was given at the wrong time because olanzapine was not administered within one hour of the scheduled time. There was no documented evidence that LVN 3 administered olanzapine to Resident 33 early at 7:30 a.m. - Metoprolol was schedule to be administered at 7:30 a.m. and LVN 3 administered it at the correct time. <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/2025 at 11:10 a.m. with LVN 3 while in the presence of RN 1, LVN 3 stated in general medications need to be administered at the scheduled time. LVN 3 stated Resident 33 ' s olanzapine, apixaban, and divalproex sodium were administered early at 7:30 a.m. because LVN 3 prefers to give Resident 33 all the morning medications at the same time. LVN 3 stated LVN 3 did not document the administration of Resident 33 ' s olanzapine, apixaban, and divalproex sodium at 7:30 a.m. when the medications were administered. LVN 3 stated LVN 3 documented later in Resident 33 ' s MAR that olanzapine, apixaban, and divalproex sodium were administered during the scheduled time of 9 a.m., but they were not administered during the scheduled time. LVN 3 stated Resident 33 ' s MAR for the a.m. med pass on 6/18/2025 was not accurate for the time of administration of olanzapine, apixaban, and divalproex sodium.</p> <p>During a follow-up interview and record review on 6/18/2025 at 11:27 a.m. with RN 1, RN 1 reviewed the facility P&P regarding medication administration and documentation. RN 1 stated the facility policy is to administer medications within one hour of the scheduled time and LVN 3 did not follow the facility P&Ps when LVN 3 administered Resident 33 ' s medications early at 7:30 a.m. RN 1 stated medications must be documented in the MAR right after administration to a resident and prior to administering medications to the next resident to ensure the documentation is correct. RN 1 stated LVN 3 did not follow the facility process when LVN 3 did not document Resident 33 ' s medications at the time of administration and when LVN 3 did not document that the medications were given early. RN 1 stated it was important that the MAR is accurate for medication time of administration because the MAR is a communication tool that is used for determining the resident ' s care. RN 1 stated for example, if something happened to Resident 33, it would be important to know what times medications were given.</p> <p>During an interview and record review on 6/20/2025 at 3 p.m. with the Director of Nursing (DON), the DON reviewed Resident 33 ' s Medication Administration Audit Report. The DON stated the facility process is to document the administration of medication in the MAR right after administering medications to ensure accurate documentation of the medication given. The DON reviewed the Medication Administration Audit Report and noted the following for Resident 33 ' s a.m. medication administration on 6/18/2025:</p> <ul style="list-style-type: none"> - Divalproex sodium was scheduled for 9 a.m., LVN 3 administered at 7:30 a.m., and LVN 3 documented the administration at 10:57 a.m. - Apixaban was scheduled for 9 a.m., LVN 3 administered at 7:30 a.m., and LVN 3 documented the administration at 10:57 a.m. - Olanzapine was scheduled for 9 a.m., LVN 3 administered at 7:30 a.m., and LVN 3 documented the administration at 10:57 a.m. <p>The DON stated it was important that the MAR accurately reflect the time of medication administration because the MAR directs the care for the resident. The DON stated when LVN 3 did not accurately document the early administration of Resident 33 ' s medications at 7:30 a.m., there was the potential for misunderstanding regarding the resident ' s care throughout the day. The DON stated the facility P&P was not followed.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility P&P titled, Charting Documentation, last reviewed 7/2024, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: Medications administered. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Documentation of procedures and treatments will include care-specific details, including: the date and time the procedure/treatment was provided.</p> <p>During a review of the facility P&P titled, Administering Medications, last reviewed 7/2024, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:</p> <ul style="list-style-type: none"> a) enhancing optimal therapeutic effect of the medication. b) preventing potential medication or food interactions; and c) honoring resident choices and preferences, consistent with his or her care plan. <p>Medication errors are documented and reported. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and document the reason. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered.</p> <p>b. During a review of Resident 70 ' s admission Record, the admission Record indicated the facility admitted the resident on 10/31/2023, and readmitted the resident on 6/13/2025, with diagnoses including major depressive disorder (a mood disorder (a mental health condition where a person experiences significant and persistent disturbances in their emotional state, going beyond normal mood fluctuations) that causes a persistent feeling of sadness and loss of interest), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and anxiety disorder (persistent and excessive worry that interferes with daily activities).</p> <p>During a review of Resident 70 ' s History and Physical (H&P), dated 6/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 70 ' s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self understood and understand others and had impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated the resident was on a high-risk drug class antipsychotic medication (a type of drug used to treat symptoms of psychosis).</p> <p>During a review of Resident 70 ' s Order Summary Report, dated 6/13/2025, the Order Summary Report indicated an order for Oxcarbazepine oral tablet 150 milligrams (mg, a unit of weight) (Oxcarbazepine). Give 3 tablet by mouth three times a day for mood disorder monitor behavior (m/b) uncontrollable extreme mood swings causing anger interfering with daily living activities. 3 tablets = 450 mg and Risperidone oral tablet 1 mg (Risperidone). Give 2 mg by mouth two times a day for psychosis m/b unpredictable behavior aeb: suddenly becoming physically aggressive. 2 tablets = 2 mg.</p> <p>During a review of Informed Consents for Trileptal and Risperidone, dated 6/13/2025, the informed consent for Trileptal 150 mg give 3 tablets by mouth three times a day was not signed and dated by the physician/prescriber and the informed consent for Risperdal 2mg by mouth two times a day was not signed and dated by the physician/prescriber.</p> <p>During a concurrent interview and record review on 6/18/2025, at 11:31 a.m., with Registered Nurse (RN) 4, reviewed Resident 70 ' s Medical Diagnosis, Order Summary Report, and Informed Consents. RN 4 stated the informed consent for Trileptal and Risperdal was not signed and dated by the physician/prescriber. RN 4 stated it should have been signed and dated by the physician after explaining the risk and benefits of taking the medication and obtaining consent from the resident or representative. RN 4 stated signing and dating the document ensures the consent was obtained from the resident/representative and the risk and benefits were explained to the resident and the date to ensure its currentness.</p> <p>During a concurrent interview and record review on 6/20/2025, at 11:57 a.m., with the DON, reviewed Resident 70 ' s Informed Consents and the facility ' s policy and procedure (P&P) titled Policy: Informed Consents. The DON stated Resident 70 ' s informed consents was not signed and dated by the physician. The DON stated they have 30 days for the physician to sign the form however; the DON was not able to provide a policy and procedure to support her claim. The DON stated per the P&P titled Informed Consents, the physician and/or prescriber must sign an informed consent form after explaining all necessary information to the resident or their representatives and a licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness. The DON stated the form is not complete as the signature and date of the prescriber is missing.</p> <p>During a review of the facilities recent P&P titled Policy: Informed Consent, last reviewed on 7/2024, the P&P indicated the physician and/or prescriber must sign an informed consent form after explaining all necessary information to the residents or their representatives. Informed consent may be obtained through the following means:</p> <ul style="list-style-type: none"> - In person - By phone - Via fax <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- By email</p> <p>A licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness.</p> <p>During a review of the facility's recent P&P titled Charting and Documentation, last reviewed on 7/2024, the P&P indicated documentation of procedures and treatments will include care-specific details including:</p> <p>a. the date and time the procedure/treatment was provided;</p> <p>g. the signature and title of the individual documenting.</p> <p>c. During a review of Resident 23 ' s admission Record, the admission Record indicated the facility admitted the resident on 1/4/2023, and readmitted the resident on 7/20/2024, with diagnoses including psychosis, mood disorder, and major depressive disorder.</p> <p>During a review of Resident 23 ' s H&P, dated 7/24/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 23 ' s MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self understood and understand others and had severe cognitive impairment (a significant decline in a person's ability to think, learn, remember, and make decisions).</p> <p>During a review of Resident 23 ' s Order Summary Report, dated 7/21/2024, the Order Summary Report indicated an order for Depakote oral tablet delayed release 125 mg (Divalproex Sodium). Give 125 mg by mouth three times a day for mood disorder m/b rapid shift from calm to agitation.</p> <p>During a concurrent interview and record review on 6/18/2025, at 11:17 a.m., with the Assistant Director of Nursing (ADON), reviewed Resident 23 ' s Informed Consent on the use of Depakote. The ADON stated the Informed Consent was missing the date the doctor signed the consent, and the box indicating how the Informed Consent was obtained was not filled out. The ADON stated it was important for the doctor to date his signature to ensure the consent was obtained currently and the means of verification of how the Informed consent should have been filled out to provide accuracy to the documentation.</p> <p>During a concurrent interview and record review on 6/20/2025, at 11:57 a.m., with the DON, reviewed Resident 23 ' s Informed Consents and the facility ' s policy and procedure (P&P) titled Policy: Informed Consents. The DON stated Resident 23 ' s informed consents was not dated by the physician and the boxes on how the nurse verified the consent was done was left unchecked. The DON stated per the P&P titled Informed Consents, the physician and/or prescriber must sign an informed consent form after explaining all necessary information to the resident or their representatives and a licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness. The DON stated the form is not complete as the signature and date of the prescriber is missing and the boxes were left unchecked on how the licensed nurse verified the informed consent.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facilities recent P&P titled Policy: Informed Consent, last reviewed on 7/2024, the P&P indicated the physician and/or prescriber must sign an informed consent form after explaining all necessary information to the residents or their representatives. Informed consent may be obtained through the following means:</p> <ul style="list-style-type: none"> - In person - By phone - Via fax - By email <p>A licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness.</p> <p>During a review of the facility's recent P&P titled Charting and Documentation, last reviewed on 7/2024, the P&P indicated documentation of procedures and treatments will include care-specific details including:</p> <ul style="list-style-type: none"> a. the date and time the procedure/treatment was provided; g. the signature and title of the individual documenting.

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 06/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** d. During a concurrent observation and interview on 6/17/2025, at 8:27 a.m., with Laundry Staff 1 (LS 1), observed a liquid container with light green fluid and was placed inside the linen cart beside the folded clean linens. LS 1 stated the liquid container belongs to her (LS 1) and it contains water.</p> <p>During a concurrent observation, and interview on 6/17/2025, at 8:28 a.m., with the Account Manager (AC), inside the clean laundry room. The AC stated there should be no water or food inside the clean laundry room for infection control. The AC stated staff were informed not to put any food, water or belongings in the clean laundry room. The AC stated LS 1 failed to follow infection control policy.</p> <p>During an interview on 6/17/2025, at 8:36 a.m., with the IP, the IP stated staff are not allowed to keep food or water inside the laundry room. The IP stated the staff were provided a locker room for personal belongings. The IP stated the reason food or water was not allowed in the clean laundry room was to prevent the clean linens from getting contaminated for infection control.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the DON, facility ' s P&P titled, Laundry Safety undated and last reviewed on 7/2024, the P&P indicated, Remember that a clean, safe and sanitary environment for you and the resident is your primary responsibility. The DON stated staff are not supposed to keep food and water inside the laundry room because it can contaminate the clean linens and for infection control.</p> <p>During a review of facility ' s P&P, titled, Policies and Practices-Infection Control dated 4/2023, the P&P indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.</p> <p>1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, nursing students, registry and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payor source.</p> <p>2. The objectives of our infection control policies and practices are to:</p> <p>a) prevent, detect, investigate, and control infections in the facility;</p> <p>b) maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to:</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Ensure Licensed Vocational Nurse (LVN) 3 disinfected the silver metal tray used to hold and transport resident medications for one of three medication carts (Station 1 Medication Cart) before and after preparing resident medications for two of five sampled residents (Residents 33 and 85) investigated during the Medication Administration task.</p> <p>2. Ensure mobile linen carts were not covered with a loosely woven/permeable (having pores or openings that permit liquids or gases to pass through) material to protect the linens inside the cart observed during infection control task.</p> <p>3. Ensure the laundry room was kept in sanitary condition. On 6/18/2025, a liquid container was placed inside the linen cart beside the clean linens inside the laundry room.</p> <p>These deficient practices had the potential to spread communicable diseases and infections among staff and residents.</p> <p>Findings:</p> <p>a. During a review of Resident 33 ' s admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2015 and most recently admitted the resident on 4/17/2025 with diagnoses that included sepsis (a life-threatening blood infection), acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in your body tissues), paranoid schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), and hypertensive chronic kidney disease (kidney damage caused by hypertension [HTN, high blood pressure]).</p> <p>During a review of Resident 33 ' s Minimum Data Set (MDS - resident assessment tool) dated 4/22/2025, the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated that the resident required partial/moderate assistance from staff for dressing, oral hygiene, and toileting; and the resident required substantial / maximal assistance from staff for mobility.</p> <p>During a review of Resident 33 ' s Order Summary Report, the Order Summary Report indicated the following orders:</p> <p>- Divalproex sodium (a medication to treat conditions related to mood regulation and the nervous system) sprinkles, oral capsule, delayed release, 125 milligrams (mg, a unit of measurement), give 250 mg by mouth three times a day for schizoaffective disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily living activities, dated 4/22/2025.</p> <p>- Apixaban (a medication to help prevent blood clots [clumps that occur when blood hardens from a liquid to a solid]), oral tablet 2.5 mg, give 2.5 mg orally two times a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis, dated 4/17/2025.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Olanzapine (a medication to treat mood disorders) oral tablet 7.5 mg, give 7.5 mg by mouth two times a day for schizoaffective disorder manifested by yelling at staff without apparent reason, dated 6/6/2025.</p> <p>- Metoprolol succinate (a medication to treat high blood pressure), give 75 mg by mouth one time a day for HTN, give with food, dated 5/8/2025.</p> <p>b. During a review of Resident 85 ' s AR, the AR indicated the facility admitted the resident on 1/22/2025 with diagnoses that included schizoaffective disorder, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dementia.</p> <p>During a review of Resident 85 ' s MDS dated [DATE], the MDS indicated the resident was able to understand others and was usually able to make themself understood. The MDS further indicated Resident 85 required partial/moderate assistance from staff for toileting, personal hygiene, bathing, and mobility.</p> <p>During a review of Resident 85 ' s Order Summary Report, the Order Summary Report indicated the following orders:</p> <p>- Divalproex sodium tablet delayed release 250 mg, give 250 mg by mouth one time a day for mood disorder manifested by uncontrollable extreme mood swings causing anger interfering with daily living activities, dated 1/22/2025.</p> <p>- Cranberry tablet 450 mg, give one tablet by mouth one time a day for urinary tract infection (UTI- an infection in the bladder/urinary tract) prevention, dated 3/21/2025.</p> <p>- Docusate Sodium (a stool softener) oral tablet, give 100 mg by mouth two times a day for constipation, dated 1/30/2025.</p> <p>- Metformin HCL (a medication to control blood sugar) oral tablet 500 mg, give one tablet by mouth in the morning for diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), take with meals, dated 1/22/2025.</p> <p>- Risperidone (a medication used to treat the symptoms of schizophrenia) oral tablet, given 0.5 mg by mouth two times a day for schizoaffective disorder manifested by inability to process internal stimuli causing anger outbursts, dated 5/9/2025.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent medication pass observation and interview on 6/18/2025 at 7:30 a.m., with LVN 3 at the Station 1 Medication Cart, LVN 3 prepared Resident 33 ' s medications on the medication cart work surface and placed the prepared medications on a silver metal tray. LVN 3 walked into Resident 33 ' s room and placed the metal tray on the resident ' s nightstand. LVN 3 did not clean the nightstand prior to placing the metal tray. LVN 3 administered Resident 33 ' s medications and then removed the silver metal tray from the nightstand, walked back to the Station 1 Medication Cart and placed the tray on the cart work surface. LVN 3 did not disinfect the metal tray or cart. LVN 3 moved the Station 1 Medication Cart to Resident 85 ' s room. Resident 85 sat in a wheelchair, eating breakfast at a bedside rolling table. LVN 3 prepared Resident 85 ' s medications on the medication cart ' s work surface. LVN 3 then placed Resident 85 ' s medications on the metal tray and walked into Resident 85 ' s room and placed the tray on Resident 85 ' s bedside rolling table. LVN 3 did not clean the bedside rolling table prior to placing the metal tray. LVN 3 administered the medications, walked out of the room, and placed the tray on the Station 1 Medication Cart. During an interview directly after the medication pass observation, LVN 3 stated LVN 3 placed the metal tray on Resident 33 ' s nightstand, the med cart, and Resident 85 ' s table without cleaning the tray or med cart between residents. LVN 3 stated the tray should be cleaned between residents to prevent the transmission of any diseases between residents, but LVN 3 was nervous and forgot to do it.</p> <p>During a concurrent interview and record review on 6/20/2025 at 3 p.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding medication administration and infection control. The DON stated all equipment is cleaned with a disinfectant wipe before and after use on residents. The DON stated medication trays are to be disinfected between use for each resident and prior to placing the tray on the medication cart to prevent contamination between residents. The DON stated the facility P&P was not followed by LVN 3 when LVN 3 did not disinfect the metal tray between Residents 33 and 85 with a potential of transmitting illness between residents.</p> <p>During a review of the facility P&P titled, Administering Medications, last reviewed 7/2024, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, etc.) for the administration of medications.</p> <p>During a review of the facility P&P titled, Infection Control, last reviewed on 7/2024, the P&P indicated the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including when and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities.</p> <p>c. During a concurrent observation and interview on 6/20/2025, at 6:20 a.m., with the Infection Preventionist (IP), observed Mobile Linen Cart A and Mobile Linen Cart B in Station B covered with a permeable/mesh material being used by the staff to store linens for residents. The IP stated she knew it has to be replaced, and the Administrator (ADM) already ordered for replacement. The IP stated she does not know why it was not replaced yet. The IP stated the Mobile Linen Carts should be covered with non-permeable material to prevent the linens from environmental contaminants that can get the residents sick.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/20/2025, at 1:56 p.m., with the District Manager (DM) and the Account Management (AC), in the basement where the Laundry Department is located, observed multiple Mobile Linen Carts covered with permeable/mesh material lined up near the entrance of the Laundry Department with clean linens inside. The DM and the AC stated the Mobile Linen Carts should not be covered with a permeable/mesh material as it allows air and water to penetrate the material that can allow external environmental contaminants to settle on the linens that can get the residents sick. The DM and the AC stated they both knew the ADM ordered for new covers, but they do not know why not all Mobile Linen Carts covers were replaced yet.</p> <p>During an interview on 6/20/2025, at 2:04 p.m., with the ADM, the ADM stated she ordered the replacement already, however there was a mistake in the ordering process. The ADM stated the vendor only replaced the dirty linen hamper but not the Mobile Linen Carts. The ADM stated the Monile Linen Carts have to be measured to replace the covers. The ADM stated the vendor made a mistake on the measurement and had to redo it. The ADM stated the failure of the facility to replace the permeable/mesh covers of the Mobile Linen Carts had the potential for cross-contamination (means harmful things, like dangerous bacteria or germs, are accidentally transferred from one place to another, causing serious consequences, often leading to severe illness or outbreaks) of infection on the linens that can make the residents sick.</p> <p>During a review of the facility's P&P titled Policies and Practices- Infection Control, last reviewed on 7/2024, the P&P indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.</p> <p>During a review of the facility's recent P&P titled Healthcare Services Group, Inc. and Its Subsidiaries Infection Control Policy, last reviewed on 7/2024, the P&P indicated linen and laundry procedures must be designed to prevent cross-contamination.</p>		

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 06/20/2025
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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. During a review of Resident 90 ' s admission Record, the admission Record indicated the facility admitted Resident 90 on 10/30/2024, with diagnoses that included metabolic encephalopathy (brain disorder resulting from chemical imbalances in the body, often caused by underlying medical conditions or organ dysfunction), sepsis (a life-threatening blood infection) due to MRSA and unspecified dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 90 ' s H&P, dated 6/9/2025, the H&P indicated Resident 90 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 90 ' s MDS, dated [DATE], the MDS indicated Resident 90 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 90 needed maximum assistance from staff for toileting and showering.</p> <p>During a review of Resident 90 ' s Physician Order, dated 6/3/2025, the Physician Order indicated vancomycin hydrochloride intravenous (within the vein) solution, use 1 gram intravenously every 12 hours for MRSA bacteremia (the presence of bacteria in the bloodstream) for three days.</p> <p>During a review of Resident 90 ' s Care Plan, dated 6/3/2025 about Resident 90 ' s risk for possible side effects or adverse reaction related to antibiotic therapy-vancomycin, the Care plan indicated an intervention to assess Resident 90 for signs and symptoms of adverse reactions or side effects and notify the physician.</p> <p>During a concurrent interview, and record review on 6/17/2025, at 8:36 a.m., with the IP, Resident 90 ' s Physician Order, dated 6/3/2025, and Progress Notes, dated 6/3/2025 to 6/5/2025 were reviewed. The IP stated there was no documented evidence that monitoring was done on 6/4/2025, and 6/5/2025 for Resident 90 ' s use of antibiotic-vancomycin. The IP stated Resident 90 was at risk for vancomycin adverse effects if not monitored and can result to Resident 90 possibly be transferred back to General Acute Care Hospital (GACH). The IP stated the facility failed to monitor Resident 90 for the use of antibiotic vancomycin.</p> <p>During a concurrent interview, and record review on 6/20/2025, at 12:34 p.m., with the Director of Nursing (DON), facility ' s policy and procedure (P&P) titled, Antibiotic Stewardship, dated 12/2016, and last reviewed on 7/2024, the P&P indicated, The purpose of our antibiotic stewardship program is to monitor the use of antibiotic in our residents. The DON stated nurses need to monitor residents every shift on the effectiveness and side effects of the antibiotic until the antibiotic dose was completed. The DON stated the importance of monitoring was to know if the antibiotic was effective and to monitor resident if they (residents) are developing side effects of the antibiotic. The DON stated the facility failed to monitor the resident for the possible side effects of antibiotic. The DON stated Residents 116 and 90 can have some type of adverse effects and cause complication that could possibly result in a delay in care.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interview and record review, the facility failed to implement an antibiotic stewardship program (a coordinated program that promotes the appropriate use of drugs used to treat infections, including antibiotics), for antibiotic use protocol (official procedure or system of rules) for three of five sampled residents (Residents 70, 116, and 90) reviewed for unnecessary medications by failing to ensure residents' use of antibiotic (Cephalexin) was monitored for its adverse effect (a negative or harmful result).</p> <p>These deficient practices had the potential for residents to have a delay in care and services brought about by undetected adverse effects of the antibiotic use and increase in antibiotic resistance (does not respond to a drug) from unnecessary or inappropriate antibiotic use.</p> <p>Findings:</p> <p>1. During a review of Resident 70's admission Record, the admission Record indicated the facility admitted the resident on 10/31/2023, and readmitted the resident on 6/13/2025, with diagnoses including chronic osteomyelitis (is an infection of the bone) of left ankle and foot, type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), with foot ulcer, and methicillin resistant staphylococcus aureus (MRSA, a bacteria that does not respond to antibiotics) infection.</p> <p>During a review of Resident 70's History and Physical (H&P), dated 6/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 70's Minimum Data Set (MDS, a resident assessment tool), dated 5/13/2025, the MDS indicated the resident sometimes have the ability to make self understood and understand others and had impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated Resident 70 was on a high-risk drug class antibiotic.</p> <p>During a review of Resident 70's Order Summary Report, dated 6/15/2025, the Order Summary Report indicated an order of Cephalexin tablet 500 milligrams (mg, a unit of weight). Give 500 mg by mouth every 6 hours for bilateral foot infection until 6/27/2025. Take first dose on 6/15/2025 from the emergency kit (e-kit, is a small supply of medications kept at the facility). The Order Summary Report did not indicate any order to monitor for the adverse effect on the use of antibiotic (Cephalexin).</p> <p>During a concurrent interview and record review on 6/18/2025, at 8:44 a.m., with the Infection Preventionist (IP), reviewed Resident 70's Medical Diagnosis, Order Summary Report, MAR, and Care Plan. The IP stated there was an order for antibiotics (Cephalexin), however there was no order for monitoring for its adverse effects. The IP also stated there was no care plan on the use of Cephalexin on the electronic health record of the resident. The IP stated it is important to monitor for the adverse effect of the antibiotic (Cephalexin) to ensure its safe use. The IP stated prompt observation and reporting of the adverse effects on the use of antibiotics prevents complications and provides timely interventions to control its adverse effects that can harm the resident.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/20/2025, at 11:57 a.m., with the Director of Nursing (DON), the DON stated the staff should have obtained an order from the attending physician to order for monitoring of adverse reactions on the use of antibiotic (Cephalexin). The DON stated monitoring the adverse effect on the use of antibiotic (Cephalexin) on Resident 70 ensures prompt treatment and intervention to lessen the discomfort and harm on the resident.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled Antibiotic Stewardship, last reviewed on 7/2024, the P&P indicated the purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents.</p> <p>During a review of the facility's recent P&P titled Antibiotic Stewardship- Orders for Antibiotics, last reviewed on 7/2024, the P&P indicated before a nurse removes an antibiotic from the emergency supply of medication, he or she will check for the right drug, right strength, allergy information and use of warfarin, along with the following:</p> <p>a. The nurse will contact the pharmacist if not familiar with the antibiotic dose or drug-drug interactions.</p> <p>2. During a record review of Resident 116 ' s admission Record, the admission Record indicated the facility admitted Resident 116 on 10/15/2024, with diagnoses that included unspecified (unconfirmed) cerebrovascular disease (a group of conditions that affect blood flow to the brain), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and vascular dementia (reduced blood flow to the brain, which damages brain tissue and impairs cognitive functions).</p> <p>During a review of Resident 116 ' s H&P Examination Visit, dated 10/15/2024, the H&P indicated Resident 116 was alert and needed visual cues (non-verbal signals that provide information, guide actions, or enhance understanding through visual elements).</p> <p>During a review of Resident 116 ' s MDS, dated [DATE], the MDS indicated Resident 116 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 116 needed maximum assistance from staff for toileting and personal hygiene.</p> <p>During a review of Resident 116 ' s Physician Order, dated 6/2/2025, the Physician Order indicated cephalexin tablet 500 mg by mouth every 12 hours for urinary tract infection (UTI-an infection in the bladder/urinary tract) for seven days.</p> <p>During a review of Resident 116 ' s Care Plan, dated 6/3/2025 about Resident 116 ' s risk for possible side effects (a secondary unwanted effect) or adverse reaction related to antibiotic therapy-cephalexin, the Care Plan indicated an intervention to assess for signs and symptoms of adverse reaction or side effects and notify the physician.</p> <p>During a review of Resident 116 ' s Physician Order, dated 6/5/2025, the Physician Order indicated the following:</p> <p>-Discontinue cephalexin 500 mg by mouth every 12 hours for UTI.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Sulfamethoxazole-trimethoprim (Bactrim) tablet 800 mg -160 mg, give one tablet by mouth every 12 hours for UTI for seven days.</p> <p>During a review of Resident 116 ' s Care Plan, dated 6/5/2025, about Resident 116 ' s risk for possible side effects or adverse reaction related to antibiotic therapy-Bactrim, the Care Plan indicated an intervention to assess for signs and symptoms of adverse reaction or side effects and notify the physician.</p> <p>During a concurrent interview and record review on 6/17/2025, at 8:36 a.m., with the Infection Preventionist (IP), Resident 116 ' s Physician Orders, dated 6/2/2025, 6/5/2025 and Progress Notes, dated 6/2/2025 to 6/12/2025 were reviewed. The IP stated there were no documented evidence that monitoring was done for the adverse effects of cephalexin and Bactrim on 6/2/2025, 6/7/2025, 6/9/2025 to 6/12/2025. The IP stated those were six days without monitoring for the adverse effect of the use of antibiotics cephalexin and Bactrim. The IP stated the importance of monitoring Resident 116 for the adverse effect and use of antibiotic was to know if the antibiotic was actually treating the infection and prevent complication. The IP stated Resident 116 can have adverse reaction from the cephalexin and Bactrim and staff cannot act fast enough to notify the physician causing a delay in care.</p>		

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 06/20/2025
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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the electrical patient care equipment was in safe operating condition for three of five sampled residents (Residents 102, 51, and 23) reviewed under environmental task by failing to ensure:</p> <ol style="list-style-type: none"> 1. Resident 102 ' s pad/tab alarm (a device that helps caregivers monitor someone, usually in bed or a chair, who might need help getting up or moving) did not have a broken sensor cord. 2. Residents 51 and 23 ' s bed remote control did not have frayed/exposed wires. <p>These deficient practices had the potential for Residents102, 51, and 23 to sustain accidents such as electrical shock and falls.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 102 ' s admission Record, the admission Record indicated the facility admitted the resident on 1/10/2024, with diagnoses including Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), age-related osteoporosis (the development of osteoporosis, a condition characterized by weakened and brittle bones, as a natural consequence of aging), and stress fracture (a tiny crack in a bone caused by repetitive stress, often from overuse in activities like running or jumping) of pelvis. <p>During a review of Resident 102 ' s History and Physical (H&P), dated 1/28/2025, the H&P indicated the resident was alert, oriented to person only, and had minimal vocalization.</p> <p>During a review of Resident 102 ' s Minimum Data Set (MDS, a resident assessment tool), dated 4/18/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has trouble with mental processes like thinking, learning, remembering, and making decisions). The MDS indicated Resident 102 was dependent to needing substantial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 102 ' s Order Summary Report, dated 6/20/2025, the Order Summary Report did not indicate an order for pad/tab alarm.</p> <p>During a review of Resident 102 ' s Fall Risk Assessment, dated 4/15/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 102 ' s Care Plan (CP) Report titled Resident has self-care deficits, last revised on 5/5/2025, the CP indicated an intervention to provide a safe environment.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 6/16/2025, at 10:06 a.m., with Restorative Nursing Assistant (RNA) 2, inside Resident 102 ' s room, observed Resident 102 had a pad/tab alarm on her bed with broken sensor pad wires laying on the floor. RNA 2 stated the pad/tab alarm will not work as the pad sensor cord was broken and not connected to the pad/tab alarm. RNA 2 stated the purpose of the pad/tab alarm was to alert the staff when the resident is getting out of bed specifically used for high risk for fall residents. RNA 2 stated if the sensor pad cords are broken, the alarm will not sound off and the resident can get out of the bed without their knowledge and fall.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the Director of Nursing (DON), the DON stated the staff should have checked Resident 102 ' s pad/tab alarm ' s functionality every time they go inside the resident ' s room. The DON stated the failure of the staff to identify the broken pad/tab alarm could lead to possible falls with injury on residents.</p> <p>During a review of the facility-provided User's Manual Mobile Monitor 1 (MM 1), mobile monitor, undated indicated to carefully read the instructional manual prior to use. Failure to comply with instructions, warnings and cautions may result in serious injury to patient. Always test system and battery before each use.</p> <p>During a review of the facility-provided Instructions for Use of Sensor Pad, undated, indicated to route cords towards the alarm unit, being careful to keep cord clear of moving assist bars, latching mechanisms and all other moving parts. Connect sensor pad to alarm. Test the system operates correctly.</p> <p>2. During a review of Resident 51 ' s admission Record, the admission Record indicated the facility admitted the resident on 12/1/2021, with diagnoses including dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness that is characterized by disturbances in thought), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 51 ' s H&P, dated 6/7/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 51 ' s MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition.</p> <p>During a review of Resident 51 ' s Fall Risk Assessment, dated 4/15/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 51 ' s Care Plan (CP) Report titled At risk for unavoidable declines, last revised on 5/5/2025, the CP indicated an intervention to provide a safe environment.</p> <p>During a concurrent observation and interview on 6/16/2025, at 11:08 a.m., with Certified Nursing Assistant (CNA) 5, inside Resident 51 ' s room, observed Resident 51 ' s bed control had frayed wires about an inch length on them. CNA 5 stated there should be no frayed wires near the resident as it can cause electrical shock. CNA 5 stated it was the responsibility of all staff to report to the Maintenance Department if there were broken beds in the facility.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/2025, at 7:17 a.m., with the Maintenance Assistant (MA), the MA stated they are responsible of making sure that the beds in the facility are working properly and safely. The MA stated there should be no open/frayed wires on Resident 51 ' s bed remote control because it can cause electrical shock.</p> <p>During an interview on 6/20/2025, at 11:57 a.m., with the DON, the DON stated the Maintenance Department is responsible of making sure the beds in the facility are functional and safe. The DON stated all staff is responsible for reporting broken equipment in the facility to the Maintenance Department. The DON stated there should be no frayed/exposed wires at the bed remote control of Resident 51 because it can cause electrical shock.</p> <p>During a review of the facility's recent policy and procedure (P&P) titled Safety and Supervision of Residents, last reviewed on 7/2024, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization.</p> <p>Resident Risks and Environmental Hazards</p> <p>a. Bed safety;</p> <p>g. Electrical safety</p> <p>3. During a review of Resident 23 ' s admission Record, the admission Record indicated the facility admitted the resident on 1/4/2023, and readmitted the resident on 7/20/2024, with diagnoses including dementia, psychosis, and suicidal ideations (means thinking about, considering, or being preoccupied with ending your own life).</p> <p>During a review of Resident 23 ' s H&P, dated 7/24/2024, the H&P indicated the resident did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 23 ' s MDS, dated [DATE], the MDS indicated the resident rarely to never hand the ability to make self-understood and understand others and had severely impaired cognition.</p> <p>During a review of Resident 23 ' s Fall Risk Assessment, dated 4/14/2025, the Fall Risk Assessment indicated the resident was high risk for falls.</p> <p>During a review of Resident 23 ' s Care Plan (CP) Report titled At risk for unavoidable declines, last revised on 5/2/2025, the CP indicated an intervention to provide a safe environment.</p> <p>During a concurrent observation and interview on 6/16/2025, at 11:09 a.m., with the Minimum Data Set Coordinator (MDSC), inside Resident 23 ' s room, observed Resident 23 ' s bed remote control had frayed/exposed wires about an inch long. The MDSC stated there should be no exposed/frayed wires near Resident 23 to prevent electrical shock to the resident.</p> <p>(continued on next page)</p>		

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 06/20/2025
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)		
<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/20/2025, at 11:57 a.m., with the DON, the DON stated the Maintenance Department is responsible of making sure the beds in the facility are functional and safe. The DON stated all staff is responsible for reporting broken equipment in the facility to the Maintenance Department. The DON stated there should be no frayed/exposed wires at the bed remote control of Resident 23 because it can cause electrical shock.</p> <p>During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 7/2024, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization.</p> <p>Resident Risks and Environmental Hazards</p> <p>a. Bed safety;</p> <p>g. Electrical safety</p>		

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 06/20/2025
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)		
<p>F 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the requirement for no more than four residents per room for two of 45 resident rooms (rooms [ROOM NUMBERS]) for ten of ten sampled residents (Residents 44, 27, 45, 58, 10, 26, 82, 11, 52, and 24).</p> <p>This deficient practice had the potential to result in inadequate space to provide sufficient nursing care and privacy for the affected residents.</p> <p>Findings:</p> <p>During a review of the facility ' s Census List, dated 6/16/2025, indicated Residents 44, 27, 45, 58, and 10 were in room [ROOM NUMBER] and in room [ROOM NUMBER] resided Residents 26, 82, 11, 52, and 24.</p> <p>During a review of the Client Accommodation Analysis Form, dated 6/17/2025, indicated rooms [ROOM NUMBERS] housed five beds per room.</p> <p>During a review of the facility ' s request for a waiver for room size, dated 6/17/2025, the waiver letter indicated, Each room listed on the attached ' Client Accommodation Analysis ' has no projections or other obstructions, which may interfere with free movement of wheelchairs and/or sitting devices. There is enough space to provide for each residents care, dignity, and privacy and the rooms are in accordance with special needs of the residents and would not have an adverse effect on residents ' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. The waiver letter indicated the room size per room:</p> <ul style="list-style-type: none"> - room [ROOM NUMBER] with five residents, total square feet (sq ft- a unit of measurement) 384.82 (76.964 sq ft each resident) - room [ROOM NUMBER] with five residents, total sq ft 357.68 (71.536 each resident) <p>During an interview on 6/18/2025 at 8:39 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated she assisted with the care of the residents including in room [ROOM NUMBER]. CNA 6 stated there were five residents in this room and Resident 27 was ambulatory, Residents 44, 45, 58, and 10 were on wheelchair, and Resident 58 also required the use of the lift machine. CNA 6 stated there was enough space for them to provide care and has no issues with the space.</p> <p>During an interview on 6/18/2025 at 11:51 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he had no issues providing care in room [ROOM NUMBER].</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Bedrooms, last reviewed on 7/2024, the P&P indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. The P&P indicated Bedrooms accommodate no more than two residents at a time.</p>		

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 06/20/2025
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)
<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that two of 44 resident rooms (rooms [ROOM NUMBERS]) for ten of ten sampled residents (Residents 44, 27, 45, 58, 10, 26, 82, 11, 52, and 24) met the square footage (sq ft-a unit of measurement) per resident in multiple resident rooms.</p> <p>The room size for these rooms had the potential to have inadequate space for resident care and mobility.</p> <p>Findings:</p> <p>During a review of the facility ' s Census List, dated 6/16/2025, indicated Residents 44, 27, 45, 58, and 10 were in room [ROOM NUMBER] and in room [ROOM NUMBER] resided Residents 26, 82, 11, 52, and 24.</p> <p>During a review of the Client Accommodation Analysis Form, dated 6/17/2025, indicated rooms [ROOM NUMBERS] housed five beds with five beds per room.</p> <p>During a review of the facility ' s request for a waiver for the room size, dated 6/17/2025, the waiver letter indicated Each room listed on the attached ' Client Accommodation Analysis ' has no projections or other obstructions, which may interfere with free movement of wheelchairs and/or sitting devices. There is enough space to provide for each residents care, dignity, and privacy and the rooms are in accordance with special needs of the residents and would not have an adverse effect on residents ' health and safety or impede the ability of any resident in the rooms to attain his or her highest practicable well-being. The waiver letter indicated the room size per room:</p> <ul style="list-style-type: none"> - room [ROOM NUMBER] with five residents, total square feet (sq ft- a unit of measurement) 384.82 (76.964 sq ft each resident) - room [ROOM NUMBER] with five residents, total sq ft 357.68 (71.536 each resident) <p>During an interview on 6/18/2025 at 8:39 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated she assisted with the care of the residents including in room [ROOM NUMBER]. CNA 6 stated there were five residents in this room and Resident 27 was ambulatory, Residents 44, 45, 58, and 10 were on wheelchair, and Resident 58 also required the use of the lift machine. CNA 6 stated there was enough space for them to provide care and had no issues with the space.</p> <p>During an interview on 6/18/2025 at 11:51 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he had no issues providing care in room [ROOM NUMBER].</p> <p>(continued on next page)</p>

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 06/20/2025
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)		
<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s policy and procedure (P&P) titled, Bedrooms, last reviewed on 7/2024, the P&P indicated all residents are provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. The P&P indicated bedrooms measure at least 80 square feet of space per resident in double rooms, and at least 100 square feet of space in single rooms. The P&P indicated Note: Individual variations on this may be permitted by federal authorities if it is demonstrated that the variation is in accordance with special needs of the resident and will not adversely affect the resident ' s health and safety.</p>		