

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055161	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  Garden Crest Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  909 Lucile Ave. Los Angeles, CA 90026	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide safe care and services for one of three sampled residents (Resident 1) by failing to: 1.Ensure Certified Nursing Assistant 1 (CNA1) and CNA 2 provided two-person physical assistance (help from two person) when they (CNA1 and CNA2) assisted Resident 1 who had a diagnosis of osteoporosis (weak and brittle bones), contracture (a stiffness, shortening at any joint, that reduces the joint's range of motion) with activities of daily living (ADL's, activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, bathing, turning, and eating). This failure had a high potential for Resident 1 to sustain injuries and harm. Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 7/30/2021 with diagnoses that included dementia (a progressive state of decline in mental abilities), age -related osteoporosis with current pathological fracture (broken bone caused by disease) of the right femur (thigh bone), anxiety disorder (a condition in which a person had excessive worry and feelings of fear, dread and uneasiness), unspecified osteoarthritis, and contracture of unspecified joint. During a review of Resident 1's Care Plan Report dated 4/9/2024 indicated Resident 1 had contractures-multiple joints and was at risk for pain, stiffness, fractures, decrease in range of motion (ROM-how far and in what direction you can a joint or muscle), and other complications. The Care Plan Report indicated interventions (specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition) including to handle Resident 1 gently during care/ADLs. The Care Plan Report indicated to provide 2 person- assist with ADLs/care. During a review of Resident 1's Initial History and Physical (H&amp;P - a comprehensive document that records a patient's medical history and a detailed physical examination performed by a healthcare provider) dated 1/17/2025, the H&amp;P indicated Resident 1 did not have the capacity (ability) to understand and make decisions. The H&amp;P indicated Resident 1 had a history of osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and osteopenia (low bone mass). During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had severe cognitive impairment (difficulty with thinking, learning, and remembering), functional limitation in both upper extremity (shoulder, elbow, wrist, hand), both lower extremity impairment (hips, knee, ankle and foot) that interfered with functions of daily living or place Resident 1 at risk for injury. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort and helper lifts or hold trunk or limbs and provides more than half the effort) from staff for eating, oral hygiene, upper body dressing, and rolling left and right. The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) on the staff for toileting hygiene, shower/bathe self and lower body dressing with dressing. During a review of Resident 1's SBAR Communication Form (SBAR-a simple, structured way to share important information), Situation (what's happening), Background (relevant history), Assessment (professional judgement), and Recommendation (action to resolve the situation) dated 8/4/2025, the SBAR indicated staff (unidentified) reported Resident 1 had grimacing (expression) of pain on the right hip when doing peri-care (the process of cleaning the genital and anal area). The SBAR indicated Charge Nurse (CN-lead nurse) notified the Registered Nurse Supervisor (team leader for nurses) Resident 1 had right hip swelling, pain when moved, and warm to touch. The SBAR indicated Resident 1 was not able to rate pain (a numbered scale to help understand how much it hurts) level. The SBAR indicated the CN provided Tylenol (pain medication) for relief. The SBAR indicated the Medical Doctor (MD) was made aware and ordered an x-ray (a form of electromagnetic radiation, similar to visible light). During a review of Resident 1's Patient Report dated 8/4/2025, the Patient Report indicated right hip, unilateral (one sided) with pelvis (the bony structure inside your hips, buttocks and pubic region), 2-3 views (images taken from different angels to get a more complete picture) X-ray indicated Resident 1 had an interval development (change or progression) of an oblique (a break in a long bone at a curved or diagonal angle to its length, typically caused by falls or other traumas) and displaced proximal femoral fracture (a fracture in the upper part of the thighbone where the bone fragments have moved out of alignment). During an interview on 8/19/2025 at 10:20 AM, with Licensed Vocational Nurse (LVN)1, LVN 1 stated the plan of care for the residents (in general) included orders, screening, observations, assessments, and the diagnoses of the residents. LVN 1 stated she (LVN1) would check the care plan for interventions or</p>		