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| 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 01/13/2026 |
| 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) |
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| <p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to immediately notify the physician of change in treatment when one of three sampled residents (Resident 1) was readmitted back from the General Acute Care Hospital(GACH) after a treatment for ruling out fracture (break or cause to break) on 12/27/2025 with right arm device upon readmission. This deficient practice has the potential for Resident 1 not provided with proper care and treatment from the Primary Care Physician (PCP). During a record review of Resident 1's admission record indicated Resident 1 was admitted on [DATE] with a diagnoses of type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities).During a record review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 12/23/25 indicated that Resident 1's cognitive (thought process) was severely impaired. The MDS indicated that Resident 1 is dependent (helper does all the efforts) during toileting, lower body dressing, and putting on/taking off footwear. During a review of Resident 1's electronic medical records progress notes, dated 12/27/2025 at 22:25, indicated that Resident 1 came back from the hospital, via ambulance with arm splint and sling on right arm due to fracture on right elbow following GACH visit. There was no documentation that the attending physician was notified of Resident 1's return to the facility, the new diagnosis of an elbow fracture, or with right arm device.During a record review of Resident1's after summary visit report from GACH dated 12/27/2025 indicated a new diagnosis of radius (elbow bone) fracture and right elbow joint pain. GACH discharge instructions to make a follow up appointment with orthopedics and under nursing communication order indicated application, splint (a support device made of hard material that keeps an injured area from moving), right posterior (back) long arm. During a concurrent interview and record review of the Progress Notes with the Director of Nurses (DON) on 1/13/2026 at 12:59 p.m., the DON stated that all Licensed Nurse are expected to notify the Physician when residents are readmitted from the GACH or when there is a change of condition. The DON stated that there is no documentation that the PCP was notified of the readmission on [DATE] in Resident 1's electronic record progress notes which are her expectation that the nurses should have done. DON stated that it is important to notify Resident 1's physician of readmission to be able to properly monitor Resident 1 and ensure continuity of care. During a concurrent interview and record review on 1/13/2026 at 1:26 p.m. with Treatment Nurse (TX), TX stated that she did not notify Resident 1's Physician regarding right arm device because she forgot. During a review of the facility's policy and procedure titled, admission Assessment and Follow up: Role of the Nurse, revised on 01/2025, indicated Contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 observation, interview and record review, the facility failed one of three sampled residents (Resident 1) by not: Completing a comprehensive assessment for one of three sample Residents (Resident 1) after readmission from General Acute Care Hospital (GACH).2. Informing and obtaining order from the Primary Care Physician (PCP) of the discharge instruction of for application, splint (a support device made of hard material that keeps an injured area from moving), right posterior (back) long arm. Developing and implementing resident centered care plan for right arm device for one of three sample residents (Resident 1), 3. Monitoring the use of the right arm device for one of three sample residents (Resident 1). These deficient practices had the potential to result in harm to Resident 1, including compromised circulation (poor blood flow) of the right arm, skin integrity breakdown, nerve compression, pain, swelling, and decrease functional use of the extremity. Findings: During a review of Resident 3's admission Records, the admission Records indicated Resident 1 was originally admitted to the facility on [DATE], and readmitted to the facility on [DATE] with diagnoses including peripheral vascular disease (a condition where blood vessels outside the heart and brain narrow, block, or spasm, reducing blood flow to the limbs (arms/legs) and organs), type two diabetes mellitus ([DM] - a disorder characterized by difficulty in blood sugar control and poor wound healing), non-pressure chronic ulcer (a small open sore or wound generally found in the stomach or on the skin) on right foot. During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool) dated 12/23/2025 indicated Resident 1 has severe cognitive impairment (significant trouble with thinking, memory, concentration, and decision-making). Resident 1 is dependent (helper does all the effort) on toileting hygiene, lower body dressing, putting on/taking off footwear. During a review of Resident 1's History and Physical (H&P) dated 12/19/2025, the H&P indicated Resident 1 does not have capacity to understand and make decisions. During a review of Resident 1's SBAR Communication Form (a healthcare tool to quickly and clearly share a patient's status, using a structured format) dated 12/27/2025, the SBAR Communication Form indicated Resident seen at 12PM with staff while giving care, resident unable to move right arm and complains of severe pain when touched and move gently. Family member at the bedside and aware of the situation. PCP was notified and was able to see resident at around 12:05PM. Resident 1 was unable to move his right arm, PCP ordered Resident 1 to be sent out via 911. At around 12:10 911 called and Resident 1 was sent to GACH at 12:20. During a review of Resident 1's Progress Notes dated 12/27/2025 at 10:25 p.m., the Progress Note indicated Resident 1 returned from the GACH via ambulance. The progress note indicated Resident 1 had arm splint and sling on his right arm due to fracture (a broken bone) on right elbow and experiencing discomfort over the affected arm. During an interview on 1/13/2026 at 10:47 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when she started working shift on 12/28/2025 she saw Resident 1 was back from the hospital, had a cast on his right arm due to radial head fracture(break in the top part of the thumb-side bone in your forearm, right where it connects to your elbow). LVN 1 stated when she came back to work Resident 1 did not have the cast on. LVN 1 stated the DON informed her that the cast had been removed because the fracture was ruled out with X-ray (a type of medical imaging that uses radiation to take pictures of the inside of your body results). During an interview on 1/13/2026 at 11:23 p.m. with Director of Rehabilitation (DOR), the DOR stated that Resident 1 returned to the facility with immobilizer (a?brace?or?splint?that stops you from bending your arm) on his right arm. The DOR stated that he did not conduct an assessment for Resident 1 when Resident returned from the hospital with immobilizer on his arm. The DOR stated that he would conduct resident assessments on admission and when there is a change in</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>resident's condition even though there is a limitation on the arm. The DOR stated since fracture on resident right arm was ruled out, the incident was not considered as change in Resident 1's condition. During an interview on 1/13/2026 at 12:44 p.m. with Director of Nursing (DON), the DON stated that she instructed one of the License Nurse to call GACH where Resident 1 was transferred on 12/27/2025 the DON stated that she requested the X-ray results from the hospital on [DATE] and the x-ray result indicated Resident 1 did not have a fracture. The DON stated that Resident 1 returned to the facility from GACH on 12/27/2025 around 10:30 PM with immobilizer on his right arm. The DON stated when residents are readmitted back to the facility her expectation is that family and physician must be notified by the Licensed Nurses readmitting a resident. The notification should be documented in Progress Notes or Resident Assessments. The Licensed Nurse must contact the GACH to gather pertinent records. The facility must conduct comprehensive assessment and skin assessment of the resident upon residents return. The DON further stated that the facility must initiate and implement care plan for any change in residents' condition. During a subsequent interview on 1/13/2026 at 12:44 p.m. and record review with the DON the record indicated no documentation of: comprehensive assessment conducted for Resident 1 upon readmission, physician order for right arm device use and monitoring for Resident 1, developing and implementing a resident-centered care plan for right arm device for Resident 1, and monitoring the use of the right arm device for Resident 1. During a review of facilities Policies and Procedures (P&P) reviewed 1/2025, titled Care Plans, Comprehensive Person-Centered, the P&P indicated that the interdisciplinary team reviews and updates the care plan when the resident has been readmitted to the facility from a hospital stay.</p> |