

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/17/2025
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the facility medication error rate (observed or identified preparation or administration of medications or biologicals which is not in accordance with the physician's order, manufacturer's specifications for the preparation and administration of the medication or biological, and professional standards of practice) was not five percent (5%) or greater. On 12/16/2025 at 9:31 AM, Licensed Vocational Nurse 1 (LVN 1) failed to administer Simethicone (an anti-gas medication used to relieve symptoms like pressure, bloating, and fullness caused by excess gas in the stomach and intestines) and Aspirin (makes blood less sticky, preventing platelets from clumping and forming dangerous clots that cause heart attacks, strokes, and other vascular issues) timely for one out of three residents (Resident53) observed during the medication administration. This failure resulted in a cumulative med error rate of 7.14% observed during the medication administration and placed Resident 53 at risk of experiencing abdominal (stomach) discomfort and complications leading to hospitalization.Findings: During a review of Resident 53's admission Record, the admission Record indicated the facility admitted the resident on 12/2/2025 with diagnoses that included malignant neoplasm (an abnormal mass of tissue from uncontrolled cell growth which could be cancerous) the large intestine (colon), surgical aftercare following surgery on the digestive system, intestinal obstruction (a blockage in the small or large intestine that stops food, fluids, and gas from passing through, often causing severe abdominal pain, vomiting, bloating, and constipation), dysarthria (a motor speech disorder making speech slurred, slow, quiet, or hard to understand due to weak or uncoordinated muscles in the mouth, tongue, vocal cords, or diaphragm) following cerebral infarction (stroke, loss of blood flow to part of the brain), atherosclerotic heart disease (plaque buildup in the arteries), and gastro-esophageal reflux disease (chronic condition where stomach acid frequently flows back into the esophagus, causing irritation, heartburn, and regurgitation) During a review of Resident 53's Minimum Data Set (MDS, a standardized resident assessment tool) dated 9/3/2025, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 53 required substantial/maximal assistance (helper does more the half the effort) for oral hygiene and was dependent on facility staff (helper does all the effort) for eating, toileting hygiene, showering, bathing herself, upper body dressing, lower body dressing, personal hygiene, and putting on and taking off footwear. The MDS indicated Resident 53 had a feeding tube (a soft, flexible tube that delivers liquid food (formula), fluids, and medicine directly into the digestive system when a person can't eat or swallow enough by mouth due to illness or injury). During a review of Resident 53's Order Summary Report dated 12/2/2025, the Order Summary Report indicated the resident had physician orders for:1. Aspirin 325 Milligrams (mg, a unit of measure for mass) 1 tablet via the gastrostomy tube (g-tube, a feeding tube inserted through the abdomen directly into the stomach, used to provide nutrition, fluids, and medicine when a person can't eat or drink enough by mouth due to swallowing issues, poor intake, or aspiration risk) one time a day for antiplatelet.2. Simethicone 1.8 ml via g-tube three times a day for gas relief. During a review of Resident 53's Medication Administration Record (MAR) dated 12/1/2025 to 12/31/2025, the MAR indicated Resident 53 was receiving the Aspirin 325 mg every day and the Simethicone 1.8 ml three times a day. The MAR indicated Resident 53 was to receive the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055161	Facility ID: 055161 If continuation sheet Page 1 of 10

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspirin at 9 AM and the Simethicone at 8 AM, 12 PM, and 9 PM. During an observation on 12/16/2025 at 9:31 AM with LVN 1 in resident 53's room, LVN 1 observed preparing and administering medication to Resident 53. LVN 1 prepared and administered the following medication to Resident 53: 1. Amlodipine (a medication used to treat high blood pressure) 10 mg.2. Atorvastatin (a medication used to lower cholesterol levels) 40 mg.3. Losartan Potassium (a medication used to treat high blood pressure) 25 mg.4. MiraLAX (a medication used to treat constipation, a blockage of stool) 17 Grams (gm, a unit of measure for mass).5. Potassium Chloride (a medication used to treat low potassium levels in the blood) 40 Milliequivalent (meq, a unit of measure for electrolytes) /15 Milliliters (ml, a unit of measure for fluid volume).6. Vitamin C (a type of supplement that provides the essential minerals crucial for immune function) 500 mg.7. Zinc Sulfate (a type of supplement) 220 mg.8. Calcium and Vitamin D3 (a type of supplement) 660-400 mg.9. Metformin (a medication used to lower blood sugar levels) 500 mg.10. Metoprolol (a medication used to treat high blood pressure) 25 mg.11. Hydralazine (a medication used to treat high blood pressure) 10 mg.12. Simethicone 1.8 ml.13. Peridex Mouth/Throat Solution (a medication used to treat the inflammation of gums) 5 ml. During a concurrent interview and record review on 12/16/2025 at 10:20 AM with LVN 1, Resident 53's physician order for Aspirin was reviewed. Resident 53's physician order indicated the resident was to receive Aspirin 325 mg via the g-tube one time a day. LVN 1 stated he could not administer Aspirin to Resident 53 because there was no supply of Aspirin 325 mg in the medication cart that he (LVN 1) could crush and give to Resident 53. LVN 1 stated the medication cart only had Aspirin 325 mg of enteric coated (a tablet with a special polymer barrier that prevents it from dissolving in the acidic environment of the stomach) that could not be crushed. LVN 1 stated he (LVN 1) would have to obtain Aspirin from the facility's stock of over-the-counter medication and give Resident 53 the Aspirin later that day (12/16/2025). During a concurrent observation, interview, and record review on 12/16/2025 at 2:11 PM with LVN 1, Resident 53's new container of Aspirin was observed and Resident 53's MAR dated 12/1/2025 to 12/31/2025 was reviewed. LVN 1 stated Aspirin 325 mg had not been given that morning (12/16/2025) because the Aspirin on hand was enteric coated and could not be crushed and given through a g-tube. LVN 1 stated the facility did not have the non-enteric coated Aspirin available in the supply room, so LVN 1 contacted the pharmacy to deliver the medication. LVN 1 stated he (LVN 1) was able to administer 325 mg of non-enteric coated Aspirin to Resident 53 at 1:04 PM. LVN 1 stated he (LVN 1) was Resident 53's nurse on 12/16/2025. LVN 1 stated he should have let the Director of Nursing (DON) know that the facility was almost out of Aspirin 325 supply so it could have been re-ordered. LVN 1 stated Resident 53's Aspirin was due to be given at 9 AM every day. LVN 1 stated Resident 53's Simethicone was due at 8 AM that morning (12/16/2025). LVN 1 stated he (LVN 1) gave Resident 53's Simethicone late that morning (12/16/2025) because he (LVN 1) was busy and could not give the medication on time. LVN 1 stated Resident 53 was supposed to get Simethicone three times a day. LVN 1 stated the window to give medication was one hour before the medication was due and one hour after the medication was due. LVN 1 stated medication had to be given on time because there was a potential for the medication to interact with other medication. During a concurrent interview and record review on 12/17/2025 at 2:35 PM with the Director of Nursing (DON), Resident 53's MAR dated 12/1/2025 to 12/31/2025 was reviewed. The DON stated when charge nurses saw there were only five pills remaining, they had to request for a refill from the pharmacy or obtain the medication from the over-the-counter stock. The DON stated LVN 1 should have requested and obtained a refill for the Aspirin when he (LVN 1) noticed there were five or less pills in the bottle. The DON stated if a medication is due at 8:00 AM the charge nurse has an hour before and an hour after the medication is due to administer the medication. The DON stated the Simethicone for Resident 53 should have been given between 7 AM -9 AM on 12/16/2025. The DON stated the administration of Simethicone to Resident 53 at 9:31 AM meant the medication was given late by 30 mins. The DON stated Resident 53 was administered Aspirin 3 hours late on 12/16/2025. The DON stated Resident 53's medication should have been given on time. The DON stated there was a (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potential for Resident 53's Simethicone and Aspirin to not be effective and lead to the resident experiencing abdominal discomfort or hospitalization if the medications were given late. During a review of the facility's Policy and Procedure (P&P) titled Administering Medication dated 1/2025, the P&P indicated Medications are administered in accordance with prescriber orders, including any required time frame. Medication administered times are determined by resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of the medication; preventing potential medication or food interactions; and honoring resident choices and preferences, consistent with his or her care plan. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store over the counter (OTC, medication available without a prescription for treating mild ailments) medications at proper temperature controls in one of one medication stockroom, as per the facility's Policy and Procedure (P&P) titled Storage of Medications dated 5/2025. This failure had the potential to expose medication stored in the stockroom to extreme temperatures leading to a decrease in medication efficacy (how well a medication works or its ability to produce the intended result) and the potential for all 56 residents to receive ineffective medication. Findings: During an interview on 12/17/2025 at 2:08 PM with Registered Nurse 1 (RN 1), RN 1 stated the facility had one medication room and a stockroom where OTC medication was stored. During a concurrent observation and interview on 12/17/2025 at 2:20 PM with the Director of Nursing (DON), the facility's stockroom was observed. The stock room was observed with shelves that stored bottles of Citrate (a medication used to treat constipation), Vitamin D3 (a type of supplement, vitamins and minerals used to provide nutrients), [NAME]-Vite (a supplement specifically formulated for people with kidney disease), Ferrous Sulfate (medication used to treat low iron levels), Benadryl (a medication used to treat allergies), Loratadine (a medication used to treat allergies), Aspirin (a medication used to treat mild to moderate pain and inflammation), Vitamin b12 (a type of supplement), Multivitamins and Minerals (types of supplements), Zinc (a type of supplement), Vitamin C (a type of supplement), Cranberry pills (a dietary supplement taken for urinary tract health), Vitamin b1 (a type of supplement), Bisacodyl (a medication used to treat constipation), Docusate Sodium (a medication used to treat constipation), Geri-tussin (medication used to treat a cold and cough), Lactobacillus (a probiotic, a medication used to help maintain the number of health bacteria in the stomach and intestines), Clear lax (a medication used to treat constipation), Sorbitol (a medication used to treat constipation), and Tylenol (acetaminophen, a medication used to treat pain a reduce fever). There was no thermometer observed in the stockroom. The DON stated the stockroom stored some of the facility's OTC medication. The DON confirmed the stockroom did not have a thermometer. The DON stated that the room felt comfortable but did not know the temperature of the room. The DON stated she did not know if the temperature in the stockroom was appropriate to store medication because there was no way of knowing what the temperature was. The DON stated there was a potential for the over-the-counter medication stored in the stockroom to lose efficacy if the temperature in the room was too high or too low. During a record review of the facility's Policy and Procedure (P&P) titled Storage of Medications dated 5/2025, the P&P indicated All medications stored within the facility will have proper handling according to state and/or federal law. All medications shall be stored under appropriate conditions, temperatures, and in an orderly manner. Medications shall be stored at appropriate temperatures. Medications required to be stored at room temperature shall be stored at a temperature of not less than 15 degrees Celsius (59 degrees Fahrenheit) or more than 30 degrees Celsius (86 degrees Fahrenheit).		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and distribution practices, by failing to: 1. Ensure three of three dry food storage containers stored in the kitchen's dry storage room, were labeled with a use by date (the last day the manufacturer guarantees the food's peak quality, flavor, and nutrient value). 2. Ensure seven of seven scoops used for dry storage foods were not left stacked upon each other, dirty. 3. Ensure 19 of 19 food dome covers (bell-shaped or dome-shaped lid used to cover food) were not stored next to a trash receptacle used for the disposal of paper towels. These deficiencies had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness to residents who received food from the facility's kitchen. Findings: During the initial kitchen tour with the Dietary supervisor (DS) on 12/15/25 at 7:50AM, three dry storage containers were observed in the kitchen's dry storage room labeled rice, flour, and sugar without a use by date. Seven scoops used for dry storage foods were observed stacked together, each scoop placed inside/on top of each other with a white powder-like substance on the bottom scoop. The DS stated that scoops should not be placed on top/inside of each other. The DS stated each scoop had to be placed on a tray. The DS stated each scoop had to be designated to a dry storage bin either for flour, sugar, or rice and each scoop had to be kept clean. The DS stated the dry storage containers had to be dated and labeled with the prepared and use by date. The DS stated there was potential for cross-contamination and for staff not to know when the food was to be used by and for food-borne illness (an illness that comes from eating contaminated food). During an observation on 12/15/2025 at 7:50 AM in the facility's kitchen, a trash receptacle used for disposal of paper towels after handwashing was observed positioned directly next to a cart holding 19 food dome covers. During a concurrent observation and interview on 12/15/2025 at 7:52 AM in the facility's kitchen with Dietary Aid (DA 1), DA 1 confirmed by stating the food dome covers were stored next to the trash receptacle and could cause cross contamination of resident's food. DA 1 stated the food dome covers would be rewashed. During an interview on 12/15/2025 at 8:05 PM with the Dietary Supervisor (DS), the DS confirmed by stating food dome covers were stored adjacent to the trash receptacle and could cause cross-contamination of resident's food. During an interview on 12/17/2025 at 1:45 PM with the Infection Preventionist (IP), the IP stated that storing food dome covers next to the trash receptacle in the kitchen could expose residents to infection. The IP stated that she (IP) provided an in-service to kitchen staff regarding infection control practices on 12/15/2025 upon becoming aware that the food dome covers were stored adjacent to a trash receptacle. During an interview on 12/17/2025 at 1:50 PM with the Director of Nursing (DON), the DON stated that storing the food dome covers adjacent to a trash receptacle could create an infection control concern, potentially contaminate resident's food, and cause residents to become ill. The DON stated the food dome covers should not be stored adjacent to the trash receptacle and should be kept at least six feet away from potential contamination sources. The DON stated the food dome covers had to be (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rewashed. During a review of facility's policy and procedures (P&P) titled Storing Utensils, Tableware, and Equipment with a revised date of 1/2025, the P&P indicated Cleaned and sanitized utensils and equipment will be stored at least six inches off the floor in a clean, dry location in a way that keeps them from contamination by splash, dust or other means. During a review of facility's policy and procedures (P&P) titled Food preparation and Service with a revised date of 1/2025, the P&P indicated Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. During a review of the 2022 U.S. Food and Drug Administration Food Code, code 4-903.11 titled Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. code indicated, (A) Except as specified in (D) of this section, cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation (claim that someone did something wrong) of misappropriation (taking or using someone else's money or belongings without their permission) of resident property immediately, but not later than 2 hours after the allegation was made to the California Department of Public Health (CDPH) for one out of one sampled resident (Resident 63) on 5/16/2025. As per the facility's policy and procedures (P&P) titled Abuse, Neglect, Exploitation (treating someone unfairly or taking improper advantage of them for personal gain, using a resident's vulnerability, or situation for one's own benefit) or Misappropriation - Reporting and Investigating, dated 1/2025. This deficient practice delayed an onsite inspection by the California Department of Public Health to ensure Resident 63's allegation was investigated. This deficient practice also had the potential to place Resident 63 at further risk for abuse. Findings: During a review of Resident 63's admission Record, the admission Record indicated the facility originally admitted Resident 63 on 1/13/2021 and readmitted Resident 63 on 12/11/2025 with diagnoses that included type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), acute respiratory failure with hypoxia (when the body's tissues and cells don't get enough oxygen to function properly), ischemic cardiomyopathy (the heart muscle gets weak and enlarged because the heart is not getting enough oxygen-rich blood), morbid obesity (having a severe level of excess body fat), myocardial infarction type 2 (the heart muscle is damaged because the heart is not getting enough oxygen due to an imbalance, not from a sudden clot, but from something else stressing the body, like severe illness, low blood count, or fast heart rate, making the heart work too hard or depriving the heart of fuel), unspecified glaucoma (diseases involving eye pressure increases that lead to permanent vision loss and blindness), and dependence on oxygen (a colorless, odorless gas that is essential for breathing). During a review of Resident 63's Progress Notes dated 5/16/2025 at 2:09 PM, the Progress Notes indicated Spoke to patient about the investigation of the missing money that he is now claiming that it is around \$2k dollars, and when over the timeline of when was it that he ask [unknown staff] that was placing in bed with the foyer and the other lady that was helping him. Patient said that he ask the lady to place it in the second drawer he said this was at night time and then is later said that it was around 3-4pm. The note also indicated Told patient we will follow up with [unknown staff] and the with the police report. During a review of Resident 63's Minimum Data Set (MDS - a standardized resident assessment tool, dated 10/7/2025, the MDS indicated Resident 63 had the ability to understand others and had the ability to make himself understood. During a review of Resident 63's History and Physical (H&P- physician's examination of a resident, in which the physician obtains a thorough medical history from the resident or resident representative, performs a physical examination, and then documents the findings) dated 12/12/2025, the H&P indicated Resident 63 had fluctuating (varying) capacity (a person's ability to think clearly and make good decisions isn't constant; the person's ability to think goes up and down) to understand and make decisions. During an interview on 12/15/2025 at 10:26 AM, with Resident 63, Resident 63 stated he had lived at the facility for approximately 2 years. Resident 63 stated he reported to the Administrator (ADM) and Social Services Director (SSD) that approximately \$2000 was stolen from his room approximately 6 months prior to the date of interview. Resident 63 stated he could not remember the exact date or time. Resident 63 stated the facility reported the alleged stolen \$2000 to the police. During an interview on 12/16/2025 at 8:14 AM with the SSD, the SSD stated he (SSD) was familiar with Resident 63's allegation regarding the stolen money. The SSD stated Resident 63 had fluctuating (changing) dollar amounts regarding how much money was stolen. The SSD stated at times Resident 63 reported missing \$300 and at other times \$3000. The SSD stated he (SSD) reported the allegation of stolen money to local law enforcement only, but could not say the exact date and time, only that it was around May 2025. The SSD stated he (SSD) was a mandated reporter (someone (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	legally required to report suspected physical or financial abuse or neglect). The SSD stated he (SSD) had to check his (SSD) notes to see if the SSD notified the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities) or CDPH of the allegation of stolen money. During a follow up interview on 12/16/2025 at 9:07 AM with the SSD, the SSD stated Resident 63's allegation of stolen money on 5/16/2025 was not reported to the Ombudsman or CDPH. The SSD stated that he (SSD) notified local law enforcement and received a police report number. The SSD stated he (SSD) should have reported the allegation to CDPH. The SSD stated he (SSD) was not well versed in the facility's abuse and misappropriation of property policies. During an interview on 12/16/2025 at 9:19 AM with the Director of Staff Development (DSD), the DSD stated she (DSD) educated staff (in general) during abuse trainings and that facility staff had to report any allegations of abuse (financial, physical, misappropriation of property) to the police, CDPH, and Ombudsman. During a concurrent interview and record review on 12/16/2025 at 9:52 AM with the Director of Nursing (DON), DSD, and SSD, the facility's P&P titled Theft and Loss Program dated 1/2025 and the facility's P&P titled Abuse, Neglect, Exploitation (treating someone unfairly or taking improper advantage of them for personal gain, using a resident's vulnerability, or situation for one's own benefit) or Misappropriation - Reporting and Investigating, dated 1/2025 were reviewed. The SSD stated he (SSD) only referred to the facility's Theft and Loss Program policy which indicated the facility will report to local law enforcement agency within 36 hours when the Administrator has reason to believe resident's property with a then current value of \$100.00 (one hundred dollar) or more has been stolen. Facility will keep logs that contain pertinent information for 12 months when Resident 63 made the allegation on 5/16/2025 regarding \$2000 being stolen. The DSD and DON stated facility staff should have referred to the policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 1/2025, which 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 regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported when Resident 63 made the allegation regarding \$2000 being stolen. During a telephone interview on 12/16/2025 at 10:20 AM with the Ombudsman (OMB), the OMB stated the OMB did not receive any notification from the facility regarding any misappropriation of property in May 2025 for Resident 63. During a concurrent interview and record review on 12/16/2025 at 11:40 AM with the ADM, the ADM reviewed the facility's P&Ps titled Theft and Loss Program and Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 1/2025. The ADM stated Resident 63's allegation on 5/16/2025 of \$2,000 being stolen would have only been reported to CDPH and the Ombudsman when the ADM's investigation was completed. The ADM stated that she (ADM) did not report the allegation Resident 63 made on 5/16/2025 because the ADM was not aware of the facility's policy and procedures titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. The ADM stated the facility should have referred to the Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy and reported Resident 63's allegations to CDPH and the Ombudsman. During an interview on 12/16/2025 at 11:57 AM with the DSD and DON, the DSD and DON stated the facility should have reported Resident 63's allegation of misappropriation of property on 5/16/2025 to protect Resident 63. The DON and DSD stated the facility had to report to CDPH and the Ombudsman any abuse or misappropriation of property allegations made by any of the facility's residents. During a review of the facility's P&P titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 1/2025, the policy 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 regulation) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. During a review of the facility's P&P titled Theft and Loss Program dated 1/2025, the policy indicated the facility will report to local law enforcement agency within 36 hours when the (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055161	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator has reason to believe resident's property with a then current value of \$100.00 (one hundred dollar) or more has been stolen. Facility will keep logs that contain pertinent information for 12 months.		

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 12/17/2025
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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure 14 out of 18 (room [ROOM NUMBER], 22, 23, 24, 25, 26, 27, 28, 33, 34, 35, 36, 37, and 38) resident rooms met the required 80 square feet per resident. This deficient practice had the potential to result in inadequate space necessary to provide safe nursing care and privacy for residents. Findings: During a review of the facility's room waiver letter dated 12/4/2025, the letter indicated the facility was requesting a room variance (room size different from required amount) for 14 out of 18 resident rooms (room [ROOM NUMBER], 22, 23, 24, 25, 26, 27, 28, 33, 34, 35, 36, 37, and 38). The room waiver letter indicated the following rooms had less than 80 square feet per bed: Room Number Floor Area Capacity room [ROOM NUMBER] 151.69 2 room [ROOM NUMBER] 289.53 4 room [ROOM NUMBER] 150.5 2 room [ROOM NUMBER] 151.69 2 room [ROOM NUMBER] 150.5 2 room [ROOM NUMBER] 150.5 2 room [ROOM NUMBER] 150.5 2 room [ROOM NUMBER] 151.38 2 room [ROOM NUMBER] 149.63 2 room [ROOM NUMBER] 148.44 2 room [ROOM NUMBER] 146.5 2 room [ROOM NUMBER] 147.25 2 room [ROOM NUMBER] 146.06 2 room [ROOM NUMBER] 148.4 2 The room waiver request letter indicated the rooms were in accordance with the special needs of the residents and would not inhibit residents from getting in and out of wheelchairs and affording sufficient freedom of movement. The space of each room will not have adverse effect on the residents' health and safety; and would not impede the ability of any resident in the rooms to attain his/her highest practicable well-being. The room waiver letter indicated all measurements will be taken to ensure the comfort of each resident, staff, and visitor and would not be compromised by the facility's existing room square footage. During an observation on 12/15/2025 at 2:00PM, the Maintenance supervisor (MS) measured rooms [ROOM NUMBERS]. The rooms measured as follows: room [ROOM NUMBER] 150.5 2 room [ROOM NUMBER] 146.5 2 During multiple observations of nursing care conducted from 12/15/2025 to 12/16/2025 in rooms [ROOM NUMBERS], nursing staff were observed with adequate space to provide care to the residents in each resident room [ROOM NUMBER] and room [ROOM NUMBER]. Each resident was observed to have privacy curtains, working call-lights, storage, and a bedside table with personal belongings stored in each resident's choice of location. During an interview on 12/15/2025 at 2:25pm with Resident 90 in room [ROOM NUMBER], Resident 90 stated the room was big enough to accommodate him (Resident 90). Resident 90 stated the size of the room didn't seem small. Resident 1 stated that all his (Resident 90) belongings fit in the room and there had never been an issue. Resident 90 stated that he was happy about how warm the room was. During an interview on 12/15/2025 at 2:45 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he was assigned to the station1 that services room [ROOM NUMBER]. LVN 1 stated the residents in room twenty-three never complained about the space in the room preventing the residents from doing anything or from receiving care. LVN 1 stated the residents received nursing services with no issues with the room size. During an interview with Resident 91 on 12/15/2025 at 3:00PM in room [ROOM NUMBER], Resident 91 had been in the same room since admission and had not had any issues with the space in the room and stated there was enough room for the staff when providing care. A review of the facility's policy and procedures (P&P) titled Resident bedrooms revised on 8/2024, the policy indicated resident bedrooms had to be designed and equipped for adequate nursing care, comfort and privacy of resident and would measure at least 80 square feet per resident in multiple resident bedrooms The Department is recommending continuation of the room waiver request.		