STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056114	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Terrace Rehabilitation & Wellness Centre, LP	2415 South Western Avenue Los Angeles, CA 90018

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1), was spoken to, and treated with respect and dignity. This deficient practice had the potential for Resident 1 to have decreased feelings of self-worth. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included schizophrenia (a mental illness that can affect thoughts, mood, and behavior) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1 ' s Minimum Data Set ([MDS]- a federally mandated assessment tool), dated 8/28/2024, the MDS indicated Resident 1 was cognitively intact (ability to reason, understand, remember, judge, and learn). During an interview on 10/25/2024 at 8:59 AM with Resident 1, Resident 1 stated a staff member spoke loudly to him as if she was yelling, when he went to get something from the vending machine outside. During a review of Resident 1 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 10/17/2024, the SBAR indicated a staff member responded to Resident 1 ' s statement that the vending machine was broken by stating I don ' t care what you want, just get your a** outside. During an interview on 10/25/2024 at 10:15 AM with the DON, the DON stated she was walking through the nurse ' s station when she heard an exchange of words between the Activity Assistant (AA) and Resident 1. The DON stated, the AA told Resident 1 The machine is working and get you ' re a** outside. The DON stated she sent the AA home after the incident and ultimately terminated the AA. The DON stated this had to be done because the AA ' s behavior was inappropriate and out of line, The DON stated the AA should not have spoken to Resident 1 or any other residents in that manner. The DON stated she had to prevent this situation from happening again to other residents in the facility. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Resident Rights- Quality of Life, dated 3/2017, the P&P indicated facility staff must speak respectfully to residents at all times.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to notify the physician of a resident's refusal to take Risperdal ([antipsychotic] medication to treat mental health condition) for one of four sampled residents (Resident 10). This deficient practice resulted in Resident 10 experiencing auditory hallucinations (an experience involving the perception of something not present and/or hearing voices that don ' t exist) and engaged in physical abuse to Resident 9. Findings: a) During a review of Resident 10 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and hypertension (HTN-high blood pressure). During a review of Resident 10 ' s Minimal Data Set ([MDS]- a federally mandated resident assessment tool), dated 10/15/2024, the MDS indicated Resident 10 ' s cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 10 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying assistance as resident completes activity) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 10 ' s medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 9/2024, the MAR indicated to administer Risperdal 2 milligrams ([mg] a unit of measurement) oral tablet (tabs), give 2 tabs (4mg) given by mouth, twice a day for schizophrenia mental behavior visual and auditory hallucinations. During a review of Resident 10 ' s situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 9/17/2024 at 5:00 p.m., the SBAR indicated Resident 10 was in Resident 9 ' s grabbing Resident 9 ' s head. The SBAR indicated Resident 10 stated I heard voices telling me to do it and I couldn ' t stop it. During a review of Resident 10 ' s progress note, dated 9/17/2024 at 10:40 p.m., the progress note indicated Resident 10 was transferred to the GACH for psychiatric evaluation (a clinical assessment of a person ' s mental health status) related to hearing voices. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10 ' s general acute care hospital (GACH) admission record, dated 9/18/2024, the GACH admission record indicated Resident 10 was admitted to the GACH on 9/18/2024 for psychiatric evaluation. The GACH admission record indicated Resident 10 tried to choke Resident 9 at the facility. b) During a review of Resident 9 ' s Face Sheet, the Face Sheet indicated Resident 9 was originally admitted to the facility on [DATE] 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), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness. During a review of Resident 9 ' s MDS, dated [DATE], the MDS indicated Resident 9 ' s cognitive skills for daily decisions making was moderately impaired. The MDS indicated Resident 9 required maximal assistance (helper does more than half the effort) from staff for ADLs. During a review of Resident 9 ' s SBAR dated 9/17/2024 at 5:07 p.m., the SBAR indicated Resident 9 was grabbed on the head by Resident 10. The SBAR indicated Resident 9 sustained redness on her neck and was monitored for negative social impact. During a telephone interview on 10/29/2024 at 4:11 p.m., with Licensed Vocational Nurse (LVN 5), the LVN 5 stated in the evening of 9/17/2024, he (LVN 5) was at the nurses ' station and heard yelling and screaming for help coming from the Resident 9 ' s room. LVN 5 stated he walked into Resident 9 ' s room and observed Resident 10 standing over Resident 9 and grabbing her neck and choking Resident 9. LVN 5 stated Resident 9 sustained skin redness around her neck and Resident 9 was scared. c) During a review of Resident 11 ' s Face Sheet, the Face Sheet indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD]-a chronic lung disease causing difficulty in breathing), Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and respiratory failure (difficulty to breath). During a review of Resident 11 ' s MDS, dated [DATE], the MDS indicated Resident 11 ' s cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDs indicated Resident 11 was dependent (helper does all the effort) from staff for ADLs. During an interview on 10/30/2024 at 8:25 a.m., with Resident 11(Resident 9 ' s roommate), Resident 11 stated on 9/17/2024 in the early evening hours (was not able to recall the time), she observed Resident 10 walked in their room (Resident 9, and 11 ' s). Resident 11 stated she asked Resident 10 to leave the room. Resident 11 stated Resident 10 was upset, angry and agitated. Resident 11 stated Resident 10 grabbed Resident 9 ' s neck and was choking her. Resident 11 stated Resident 9 was vulnerable (to be easily physically or mentally hurt) and was not able to defend herself. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/30/2024 at 9:30 a.m., with the Director of Nursing (DON), Resident 10 ' s MAR, dated 9/2024, was reviewed. The DON stated the MAR indicated Resident 10 was to be administered Risperdal 2 mg (4 mg) twice a day for schizophrenia mental behavior visual and auditory hallucinations. The DON stated the MAR indicated from 9/4/2024 to 9/17/2024, 24 doses should have been given. The DON stated 20 doses of Risperdal oral tablet 2 mg was marked 2 (2=drug refused) and not given to Resident 10. The DON stated Resident 10 refused 20 doses of Risperdal 2 mg , placing Resident 10 at risk for visual and auditory hallucinations. The DON stated there was no documentation the licensed nurses notified Resident 10 ' s physician of the resident ' s refusal of Risperdal. The DON stated the licensed nurses should have notified the physician regarding Resident 2's non-compliance with the medication. During a review of the facility ' s Policy and Procedure (P&P) tilted Change of Condition Notification, revised 4/1/2024, the P&P indicated the facility would ensure resident ' s physician was informed of resident change in the condition in a timely manner. The P&P indicated facility staff would promptly inform resident ' s physician when there was a significant change in the resident ' s physical, mental or psychosocial status, e.g. , deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complication . During a review of the facility ' s P&P titled Medication- Administration, revised 1/1/2012, the P&P indicated if resident was refusing to take medication the licensed nurse would attempt to give the medication several times, but if resident would continue to refuse after one hour the licensed nurse would notify physician and document in the medical record.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview, and record review, the facility failed to ensure residents were free from physical abuse for one of four sampled residents, (Resident 9). This deficient practice resulted in Resident 9 being choked by Resident 10 and had the potential for Resident 9 to have psychological and/or psychosocial distress. Findings: A. During a review of Resident 9 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was originally admitted to the facility on [DATE] 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), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (loss of muscle strength). During a review of Resident 9 ' s Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 7/19/2024, the MDS indicated Resident 9 ' s cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 9 required maximal assistance (helper does more than half the effort) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 9 ' s situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 9/17/2024 at 5:07 p.m., indicated Resident 9 was grabbed by the head by Resident 10. The SBAR indicated Resident 9 sustained redness on her neck. B. During a review of Resident 10 ' s Face Sheet indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), hypertension (HTN-high blood pressure), and muscled weakness. During a review of Resident 10 ' s MDS, dated [DATE], the MDS indicated Resident 10 ' s cognitive skills for daily decisions making was intact. During a review of Resident 10 ' s SBAR, dated 9/17/2024 at 5:00 p.m., indicated Resident 10 was in Resident 9 ' s room and grabbed Resident 9 ' s head to choke her. The SBAR indicated Resident 10 stated I heard voices telling me to do it, and I couldn ' t stop it. During a review of Resident 10 ' s progress note, dated 9/17/2024 at 10:40 p.m., indicated Resident 10 was transferred to the GACH for psychiatric evaluation (a clinical assessment of a person ' s mental health status) related to hearing voices. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10 ' s general acute care hospital (GACH) admission record, dated 9/18/2024, the GACH admission record indicated Resident 10 was admitted to the GACH on 9/18/2024 for psychiatric evaluation. The GACH admission record indicated Resident 10 tried to choke Resident 9 at the facility. During a telephone interview on 10/29/2024 at 4:11 p.m., with Licensed Vocational Nurse (LVN 5), the LVN 5 stated in the evening of 9/17/2024, he (LVN 5) was at the nurses ' station and heard yelling and screaming for help coming from the Resident 9 ' s room. LVN 5 stated he walked into Resident 9 ' s room and observed Resident 10 standing over Resident 9, grabbing her by the neck with his hands and choking Resident 9. LVN 5 stated Resident 9 sustained skin redness around her neck and Resident 9 was scared. C. During a review of Resident 11 ' s Face Sheet, the Face Sheet indicated Resident 11 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease ([COPD]-a chronic lung disease causing difficulty in breathing), Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing), and respiratory failure (difficulty to breath). During a review of Resident 11 ' s MDS, dated [DATE], the MDS indicated Resident 11 ' s cognitive skills for daily decisions making was intact. The MDS indicated Resident 11 was dependent (helper does all the effort) from staff for ADLs. During an interview on 10/30/2024 at 8:25 a.m., with Resident 11, Resident 11 stated on 9/17/2024 in the early evening hours (was not able to recall the time), she observed Resident 10 in their room (Resident 9, and 11). Resident 11 stated, she asked Resident 10 to leave the room. Resident 11 stated, Resident 10 was upset, angry and agitated. Resident 11 stated Resident 10 grabbed Resident 9 ' s neck and was choking her. Resident 11 stated Resident 9 was vulnerable (to be easily physically or mentally hurt) and was not able to defend herself. During an interview on 10/30/2024 at 9:00 a.m., with Director of Nursing (DON), the DON stated Resident 10 ' s action toward Resident 9 was resident to resident physical abuse. The DON stated residents at the facility shall be free from physical abuse. During a review of the facility ' s Policy and Procedure (P&P) titled Abuse-Reporting & Investigations, revised 3/2018, the P&P indicated facility would protect the health, safety, and welfare of facility residents. During a review of the facility ' s P&P tilted Abuse Prevention and Management, dated 6/12/2024, the P&P indicated the facility should identify, correct, and intervene in situations in which abuse is more likely to occur. During a review of the facility ' s P&P titled Resident Rights- Quality of Life, revised 3/2017, the P&P indicated facility would ensure that each resident would receive the necessary care to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The P&P indicated facility staff should promote, maintain, and protect resident privacy, including bodily privacy.

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(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	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to report an alleged physical abuse for two of four sampled residents (Resident 9 and Resident 10), by failing to: 1. Ensure facility staff report no later than two hours, the alleged resident to resident physical abuse to the California Department of Public Health (CDPH). 2. Ensure the facility report the results of the investigations within five (5) working days. These deficient practices resulted in a delay of an onsite investigation by CDPH and had the potential to place all residents in the facility at risk for further abuse. Findings: a) During a review of Resident 9 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was originally admitted to the facility on [DATE] 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), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (loss of muscle strength). During a review of Resident 9 ' s Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 7/19/2024, the MDS indicated Resident 9 ' s cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 9 required maximal assistance (helper does more than half the effort) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 9 ' s situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 9/17/2024 at 5:07 p.m., indicated Resident 9 was grabbed by the head by Resident 10. The SBAR indicated Resident 9 sustained redness on her neck. b) During a review of Resident 10 ' s Face Sheet indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), hypertension (HTN-high blood pressure), and muscled weakness. During a review of Resident 10 ' s MDS, dated [DATE], the MDS indicated Resident 10 ' s cognitive skills for daily decisions making was intact. (continued on next page)

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(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	During a review of Resident 10 ' s SBAR, dated 9/17/2024 at 5:00 p.m., indicated Resident 10 was in Resident 9 ' s room, holding Resident 9 by the head. The SBAR indicated Resident 10 stated I heard voices telling me to do it, and I couldn ' t stop it. During a review of Resident 10 ' s progress note, dated 9/17/2024 at 10:40 p.m., indicated Resident 10 was transferred to the GACH for psychiatric evaluation (a clinical assessment of a person ' s mental health status) related to hearing voices. During a review of Resident 10 ' s general acute care hospital (GACH) admission record, dated 9/18/2024, the GACH admission record indicated Resident 10 was admitted to the GACH on 9/18/2024 for psychiatric evaluation. The GACH admission record indicated Resident 10 tried to choke Resident 9 at the facility. During a telephone interview on 10/29/2024 at 4:11 p.m., with Licensed Vocational Nurse (LVN 5), LVN 5 stated in the evening of 9/17/2024, he was at the nurses ' station and heard yelling and screaming for help coming from the Resident 9 ' s room. LVN 5 stated he walked into Resident 9 ' s room and was observed Resident 10 standing over Resident 9 and holding her neck with his hands and choking Resident 9. LVN 5 stated Resident 9 sustained skin redness around her neck and Resident 9 was scared. LVN 5 stated he did not report resident to resident physical abuse to the California Department of Public Health (CDPH). During a concurrent interview and record review on 10/30/2024 at 9:30 a.m., with the DON, Resident 10 ' s SBAR and progress note, dated 9/17/2024 was reviewed. The DON stated Resident 10 ' s SBAR and progress note indicated there was a physical altercation between Resident 9 and Resident 10. The DON stated Resident 10 touching Resident 9 ' s head and grabbing her neck was a physical abuse. The DON stated, the staff should have reported alleged abuse to her (DON) and/or Administrator (ADM). The DON stated residents at the facility shall be free from physical abuse. During an interview on 10/30/2024 at 11:10 a.m., ADM, the ADM stated the incident between Resident 9 and 10 should have been reported immediately to CDPH within two hours, per facility ' s policy. During a review of the facility ' s P&P titled Abuse-Reporting & Investigations ' , revised 3/2018, the P&P indicated: 1. Allegations of abuse should be reported to the Administrator or designated representative immediately. 2. Administrator or designated representative would receive of an incident or suspected incident of resident abuse would initiate an investigation immediately. 3. Facility promptly and thoroughly investigates allegations of resident abuse. 4. Facility should report all allegations of abuse as required by law and regulations to the CDPH within two (2) hours of initial report. 5. The Administrator would provide a written report of the results of all abuse investigations and appropriate action taken to the CDPH within five (5) working days of the reported allegations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview, and record review the facility failed to implement its abuse policy and procedure (P&P) by failing to investigate a resident-to-resident physical abuse between two of four sampled residents (Resident 9 and Resident 10). This deficient practice resulted in unidentified abuse in the facility to Resident 9 and failed to protect other residents in the facility from abuse. Findings: a) During a review of Resident 9 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was originally admitted to the facility on [DATE] 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), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and muscle weakness (loss of muscle strength). During a review of Resident 9 ' s Minimum Data Set ([MDS] - a federally mandated resident assessment tool), dated 7/19/2024, the MDS indicated Resident 9 ' s cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 9 required maximal assistance (helper does more than half the effort) from staff for activities of daily living ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 9 ' s situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 9/17/2024 at 5:07 p.m., indicated Resident 9 was grabbed by the head by Resident 10. The SBAR indicated Resident 9 sustained redness on her neck. b) During a review of Resident 10 ' s Face Sheet indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), hypertension (HTN-high blood pressure), and muscled weakness. During a review of Resident 10 ' s MDS, dated [DATE], the MDS indicated Resident 10 ' s cognitive skills for daily decisions making was intact. The MDS indicated Resident 10 required supervision or touching assistance (helper provides verbal cues and /or touching/steadying assistance as resident completes activity) from staff for ADLs. During a review of Resident 10 ' s SBAR, dated 9/17/2024 at 5:00 p.m., the SBAR indicated Resident 10 was in Resident 9 ' s room, holding Resident 9 ' s head. The SBAR indicated Resident 10 stated I heard voices telling me to do it, I couldn ' t stop it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056114	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Terrace Rehabilitation & Wellness Centre, LP	2415 South Western Avenue Los Angeles, CA 90018

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10 ' s progress note, dated 9/17/2024 at 10:40 p.m., the progress noted indicated Resident 10 was transferred to the GACH for psychiatric evaluation (a clinical assessment of a person ' s mental health status) related to hearing voices. During a review of Resident 10 ' s general acute care hospital (GACH) admission record, dated 9/18/2024, the GACH admission record indicated Resident 10 was admitted to the GACH on 9/18/2024 for psychiatric evaluation. The GACH admission record indicated Resident 10 tried to choke Resident 9 at the facility. During a telephone interview on 10/29/2024 at 4:11 p.m., with Licensed Vocational Nurse (LVN 5), the LVN 5 stated in the evening of 9/17/2024, he was at the nurses ' station and heard yelling and screaming for help coming from the Resident 9 ' s room. LVN 5 stated he walked into Resident 9 ' s room and observed Resident 10 choking Resident 9. LVN 5 stated Resident 9 sustained skin redness around her neck and Resident 9 was scared. LVN 5 stated both residents were separated immediately. LVN 5 stated resident to resident physical abuse was reported to the Director of Nursing (DON). LVN 5 stated he did not report resident to resident physical abuse to the California Department of Public Health (CDPH). During an interview on 10/30/2024 at 9:00 a.m., with Director of Nursing (DON), the DON stated she was not aware of the incident between Resident 9 and Resident 10. The DON stated, she would check in the medical record. During a concurrent interview and record review on 10/30/2024 at 9:30 a.m., with the DON, Resident 10 ' s SBAR and progress note, dated 9/17/2024 was reviewed. The DON stated Resident 10 ' s SBAR and progress note indicated there was a physical altercation between Resident 9 and Resident 10. The DON stated Resident 10 grabbed Resident 9 ' s head and choked her neck was a form of physical abuse. The DON stated, staff should have reported alleged abuse to her (DON) and/or Administrator (ADM) and investigated immediately (no later than two hours). The DON stated residents at the facility shall be free from physical abuse. During an interview on 10/30/2024 at 11:10 a.m., ADM, the ADM stated he could not find any documented evidence of an investigation of the incident between Resident 9 and Resident 10. The ADM stated the incident should have been reported and investigated immediately, within two hours per facility ' s policy. During a review of the facility ' s P&P tilted Abuse Prevention and Management, dated 6/12/2024, the P&P indicated the facility should identify, correct, and intervene in situations in which abuse is more likely to occur. During a review of the facility ' s P&P titled Abuse-Reporting & Investigations ' , revised 3/2018, the P&P indicated: 1. Allegations of abuse should be reported to the Administrator or designated representative immediately. 2. Administrator or designated representative would receive of an incident or suspected incident of resident abuse would initiate an investigation immediately. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Facility promptly and thoroughly investigates allegations of resident abuse. 4. Facility should report all allegations of abuse as required by law and regulations to the CDPH within two (2) hours of initial report. 5. The Administrator would provide a written report of the results of all abuse investigations and appropriate action taken to the CDPH within five (5) working days of the reported allegations. During a review of the facility ' s P&P titled Resident Rights- Quality of Life, revised 3/2017, the P&P indicated facility would ensure that each resident would receive the necessary care to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49131 Based on observation, interview, and record review, the facility failed to: 1. Ensure one of four sampled residents (Resident 4), had a fall risk reassessment done again after Resident 4 was found on the floor on 10/12/2024 and on 10/19/2024. 2. Ensure one of four sampled residents (Resident 5), had floor mats at the bedside to prevent injury from a fall. These deficient practices resulting in Resident 4 ' s fall risk assessment not being re-evaluated to prevent future falls and had the potential for injury if Resident 5 were to have a fall. Findings: 1. During a review of Resident 4 ' s Admission Record, the Admission Record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty in walking, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparalysis (a condition that causes partial weakness or an inability to move on one side of the body). During a review of Resident 4 ' s Minimum Data Set ([MDS]- a federally mandated assessment tool), dated 10/11/2024, the MDS indicated Resident 4 had moderately impaired cognition (ability to reason, understand, remember, judge, and learn). The MDS also indicated Resident 4 had an impairment on one side of the upper extremities (arms) and lower extremities (legs) which had functional limitation in range of motion (limited ability to move that interferes with daily function). During a review of Resident 4 ' s SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 10/12/2024, the SBAR indicated Resident 4 was found on the floor. During a review of Resident 4 ' s SBAR, dated 10/19/2024, the SBAR indicated Resident 4 rolled off the bed and fell on the fall mat. During a review of Resident 4 ' s medical chart, the Fall Risk Evaluation was only done on 10/4/2024, the date of his admission to the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/25/2024 at 12:42 PM with Registered Nurse (RN) 2, Resident 4 ' s medical chart was reviewed. RN 2 stated the Fall Risk Evaluation form should be done upon admission, quarterly, a change of condition, and after a fall. RN 2 stated if a resident is found on the floor and it is unknown how the resident got on the floor, they must assume the resident fell . RN 2 stated the only Fall Risk Evaluation form that was done was on 10/4/2024. RN 2 stated it should have been done again on 10/12/2024 and 10/29/2024 when Resident 4 was found on the floor. RN 2 stated the Fall Risk Evaluation form needs to be done after a fall to accurately reflect the changes in the resident and to identify if there are other interventions that can benefit the resident. 2. During an observation on 10/24/2024 at 1:24 PM, Resident 5 was observed lying in bed with no fall mats on either side of the bed. During a review of Resident 5 ' s Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, schizophrenia (a mental illness that can affect thoughts, mood, and behavior) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 5 ' s Minimum Data Set, dated dated [DATE], the MDS indicated Resident 5 had moderately impaired cognition. The MDS also indicated Resident 5 had an impairment on both side of the upper extremities and lower extremities which had functional limitation in range of motion. During a review of Resident 5 ' s Order Summary Report, the Order Summary Report indicated Resident 5 was to have bilateral (both sides) 1/2 side rails, low bed, and bilateral floor mats, while in bed for safety every shift. During a concurrent observation and interview on 10/28/2024 at 10:00 AM with Certified Nurse Assistant (CNA) 2, CNA 2 stated her role was to monitor Resident 5 because they are confused and at risk for falls. CNA 2 stated there were no fall mats by the bed for Resident 5. During an interview on 10/28/2024 at 11:59 AM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated residents who have fall mats ordered should have the fall mats placed by the residents ' bed. LVN 4 stated she did not recall seeing fall pads by Resident 5 ' s bedside. LVN 4 stated the purpose of the fall pads was to prevent a resident from hurting or injuring themselves if they do fall out of bed. LVN 4 stated, if the resident does have the fall mat in place, the resident could be injured. During a review of the facility ' s policy and procedure (P&P) titled Fall Management Program, dated 3/31/2021, the P&P indicated the purpose is to provide residents a safe environment that minimizes complications associated with falls. The P&P indicated a licensed nurse will conduct a new fall risk evaluation quarterly, annually, upon identification of a significant change of condition, post fall and as needed.