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	12/19/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to: 1. Implement its policy and procedure (P&P) titled Resident Right-Quality of Life revised 3/2017, which indicated the facility staff would not handle or move a resident ' s personal belongings without the resident ' s permission for one of three sampled residents (Resident 1). This deficient practice violated Resident 1 ' s rights and had the potential negatively impact Resident 1 ' s psychosocial well-being. Findings: During a review of Resident 1 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizophrenia (a mental illness that is characterized by disturbances in thought), and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/16/2024, the MDS indicated Resident 1 cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching 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 1 ' s progress note, dated 12/3/2024, the progress note indicated Resident 1 was transferred to the general acute care hospital (GACH) for evaluation and treatment. The progress note indicated Resident 1 ' s belongings were kept in the facility. During a review of Resident 1 ' s progress note, dated 12/9/2024, the progress note indicated Resident 1 returned to the facility. (continued on next page)

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
	056114	A. Building B. Wing	12/19/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/16/2024 at 10:33 a.m., with Resident 1, Resident 1 stated upon return to the facility from GACH he was transferred from his original room (room [ROOM NUMBER]) into the current room (room [ROOM NUMBER]) at the facility. Resident 1 stated facility transferred his personal belonging without his permission. Resident 1 stated he was missing eyeglasses, phone changer, and other personal belongings. Resident stated facility was not able to provide him with his personal belongings inventory list. Resident 1 stated the facility did not helping him to locate his belongings. Resident 1 stated he was upset and felt ignored. During an interview on 12/16/2024 at 10:45 a.m., with the Social Worker (SW), the SW stated the facility policy was residents ' personal belonging inventory list was completed upon admission, readmission and as needed when residents bring new personal staff into the facility. The SW stated Certified Nursing Assistant (CNAs) were responsible for completing residents ' belongings inventory list and placing it in the resident medical record chart. The SW stated was important for residents to have personal belongings inventory list at the facility for resident to know what belongings they have, and for staff to know if resident personal belongings would be loss or missed placed at the facility. The SW stated it was facility policy not to move residents ' personal belongings without resident ' s permission. During a concurrent interview and record review on 12/16/2024 at 11:45 a.m., with CNA 1, CNA 1 stated Resident 1 was transferred to the GACH, and his personal belongings were placed in the boxes for safe keeping at the facility. CNA 1 stated it was the CNAs responsibilities to complete Resident 1 ' s personal belonging inventory list upon GACH transfer and upon return to the facility. CNA 1 stated personal belonging inventory list would be placed in resident medical record chart. Resident 1 ' s medical record chart was reviewed with Resident 1. CNA 1 stated she was not able to provide a copy of Resident 1 ' s personal belonging inventory list because it was not done. CNA 1 stated she was not aware if Resident 1 give permission for his personal belongings to be placed in the boxes and moved out of the room. 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 each resident receives the necessary care and services, consistent with care plan to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The P&P indicated facility staff would not handle or move a resident ' s personal belongings without the resident ' s permission.

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	12/19/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Olanzapine ([antipsychotic] medication to treat mental health condition) for one of three sampled residents (Resident 3). This deficient practice had the potential to result in Resident 3 delusional thoughts (false beliefs) and resulted in Resident 3 to engaging in physical abuse with Resident 2. Findings: A)During a review of Resident 3 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included schizophrenia (a mental illness that can affect thoughts, mood, and behavior), bipolar disorder, hypertension (HTN-high blood pressure), and muscle weakness (loss of muscle strength). During a review of Resident 3 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 10/8/2024, the MDS indicated Resident 3 ' s cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 3 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) from staff for Activities of Daily Livings ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3 ' s medication administration records ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 11/2024 and 12/2024, the MAR indicated to administer Olanzapine 10 milligram ([mg] a unit of measurement) oral tablet, one (1) tablet by mouth, two times per day for schizophrenia mental behavior delusional thoughts. During a review of Resident 3 ' s progress note (a written report of a patient ' s health status), dated 12/14/2024 at 6:16 a.m., the progress note indicated Resident 3 raised his hand with close fist and hit Resident 2 on her chest. The progress note indicated Resident 3 was arrested because of the physical altercation (argument). During a telephone interview on 12/17/2024 at 7:45 a.m., with Licensed Vocational Nurse (LVN 1), the LVN 1 stated in the morning of 12/14/2024 approximately 6:30 a.m., she (LVN 1) was at the nurse ' s station and observed Resident 3 walking in the hallway, and Resident 2 was seating on the wheelchair on the hallway. LVN 1 stated Resident 3 walked toward Resident 2, raised his hand and with close fist hit Resident 2 on her chest. (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	12/19/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 9:00 a.m., with Director of Nursing (DON), the DON stated in the morning of 12/14/2024 at 6:30 a.m., LVN 1 notified her that there was a resident-to-resident altercation at the facility. The DON stated Resident 3 hit Resident 2 on the chest. The DON stated LVN 1 reported the incident to the police. The DON stated when the police officer was at the facility and arrested Resident 3 for aggressive behavior. During a concurrent interview and record review on 12/17/2024 at 11:36 a.m., with Registered Nurse (RN 1), Resident 3 ' s MAR dated 11/2024 and 12/2024, was reviewed. RN 1 stated the MAR indicated Resident 3 was to be administered Olanzapine 10 mg 1 tablet two times per day for schizophrenia mental behavior delusional thoughts. RN 1 stated the MAR indicated there was 22 consecutive days from 11/22/2024 to 12/13/2024, Olanzapine oral tablet 10 mg at 9:00 a.m., and 9:00 p.m., was marked 2 (2=drug refused). RN 1 stated Resident 3 refused Olanzapine 10 mg for 22 consecutive days, placing Resident 3 at risk for increased mental behavior, delusional thoughts, and physical aggression toward other residents at the facility. RN 1 stated there was no documentation the licensed nurses notified Resident 3 ' s physician of the resident ' s refusal of Olanzapine. RN 1 stated the licensed nurses should have notified the physician regarding Resident 3 ' s non- compliance with the medication. B) During a review of Resident 2 ' s Face Sheet, the Face sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included dementia (a progressive state of decline in mental abilities), depression (mental health condition that involves low mood or loss of interest in activities), and muscle weakness. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 cognitive skills for daily decisions making was moderately impaired. The MDS indicated Resident 2 was dependent (helper does all the effort) from staff for ADLs. During a review of Resident 2 ' s situation, background, assessment, recommendation-a communication tool ([SBAR]-used by healthcare workers when there is a change of condition among the residents), dated 12/14/2024 at 6:35 a.m., the SBAR indicated Resident 2 was hit on the chest by Resident 3. The SBAR indicated Resident 2 reported pain rated at a 7 out of 10 on a pain scale (0=no pain, 1-3=mild pain, 4-6=moderate pain, 7-10= severe pain). The SBAR indicated Resident 2 was given Tylenol (medication to treat pain) and was monitored for negative social impact. During a review of the facility ' s policy and procedure (P&P) titled Change of Condition Notification, revised 4/1/2015, 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 P&P tilted 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.

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	12/19/2024

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to implement its policy and procedure (P&P) titled Readmission, revised 10/01/2013, which indicated the facility would provide readmission of the residents who require skilled nursing care at the facility, and allow residents who were previously at the facility to be readmitted to the facility for one of three sampled residents (Resident 3). This resulted in the denial of Resident 3 ' s right to return to his home in the facility. Findings: A) During a review of Resident 3 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3 diagnoses included schizophrenia (a mental illness that can affect thoughts, mood, and behavior), 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 3 ' s Minimum Data Set ([MDS] a resident assessment tool), dated 10/8/2024, the MDS indicated Resident 3 ' s cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 3 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) from staff for Activities of Daily Livings ([ADLs]- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3 ' s progress note (a written report of a patient ' s health status), dated 12/14/2024 at 9:27 a.m., the progress note indicated Resident 3 had a resident-to-resident altercation (argument) with Resident 2 and law enforcement (police officer) was contacted. The progress note indicated the police officer arrested Resident 3. B) During a review of Resident 2 ' s Face Sheet, the Face sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses included dementia (a progressive state of decline in mental abilities), depression (mental health condition that involves low mood or loss of interest in activities), and muscle weakness. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated Resident 2 cognitive skills for daily decisions making was moderately impaired. The MDS indicated Resident 2 was depended (helper does all the effort) from staff for ADLs. During a telephone interview on 12/17/2024 at 7:45 a.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated on 12/14/2024 at approximately 6:30 a.m., Resident 3 walked toward Resident 2 and hit her (Resident 2) on the chest. LVN 1 stated both residents were separated. LVN 1 stated she called and reported the incident to the police. LVN 1 stated police arrived at the facility and arrested Resident 3. LVN 1 stated Resident 3 was transported by police officer out of the facility. (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	12/19/2024

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/17/2024 at 9:00 a.m., with the Director of Nursing (DON), the DON stated on 12/14/2024 at 6:30 a.m., LVN 1 notified her Resident 3 hit Resident 2 on the chest. The DON stated LVN 1 reported the incident to the police. During an interview on 12/17/2024 at 11:45 a.m., with the DON, the DON stated the facility received a phone call from the police officer and was informed that Resident 3 would be released from jail and sent back to the facility. The DON stated the facility would not provide Resident 3 with care and services anymore. The DON stated facility would not re admit Resident 3 back to the facility. During an interview on 12/17/2024 at 12:10 p.m., with the Administrator (ADM), the ADM stated the facility would not readmit Resident 3 back to the facility. During a phone interview on 12/18/2024 at 10:19 a.m., with the police officer (PO 1), the PO 1 stated on the morning of 12/14/2024 (did not remember exact time) he (PO 1), received a report for a resident-to-resident altercation at the facility. PO 1 stated he arrived at the facility on 12/14/2024 at approximately 6:30 a.m. and met with LVN 1 and Resident 3 in Resident 3 ' s room. The PO 1 stated LVN 1 reported that Resident 3 hit Resident 2 and she (LVN 1) wanted Resident 3 to be arrested for assault (physical contact) and battery (knowingly causing bodily harm). The PO 1 stated he advised LVN 1 to have Resident 3 get a psychiatric evaluation (a mental health assessment that evaluates a person ' s emotional, behavioral, and psychological well-being) at the facility and transported to the hospital if necessary. The PO 1 stated LVN 1 called the DON, and both (LVN 1, and DON) demanded Resident 3 be arrested. The PO 1 stated LVN 1 was provided with a document titled Private Person ' s Arrest Statement Form, ([PPASF] a document that a private person must complete and sign after making an arrest), dated 12/14/2024 at 6:30 a.m. The PO 1 stated, the PPASF indicated LVN 1 signed the PPASF to have Resident 3 taken into custody (a circumstance in which a person is deprived of his freedom) by the PO. The PO 1 stated Resident 3 was transported to the police station, for battery charges. The PO 1 stated on the evening of 12/14/2024 approximately 7:30 p.m., he received a phone and was informed that Resident 3 would be released from the jail and needed to be picked up and transported back to the facility. The PO 1 stated he called the facility and informed the facility Resident 3 would be released from the jail and coming back at the facility. The PO 1 stated the facility stated Resident 3 could not come back and would not be provided with care and services. The PO 1 stated he picked up Resident 3 from the jail and transported Resident 3 to the GACH on 12/14/2024. During a review of the facility ' s P&P titled Readmission , revised 10/1/2013, the P&P indicated facility would provide readmission of the residents who require skilled nursing care at the facility. The P&P indicated facility would allow residents who were previously residents at the facility to be readmitted to the facility. During a review of the All Facilities Letter (AFL 23-37) from California Department of Public Health ([CDPH] state licensing and certification agency), dated 12/22/2023, the AFL indicated skilled nursing facilities (SNFs) must provide residents with equal access to quality care regardless of diagnosis, severity of condition, or payment source.

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	12/19/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on observation, interview, and record review, the facility failed to implement resident-centered care plan interventions for one of three sampled residents (Resident 5), who was at risk for wandering (walk from place to place) and had physician orders for one-to-one sitter ([1:1]-a single staff member is assigned to constantly observe and supervise a patient). This deficient practice had the potential to negatively affect all resident ' s well-being and privacy at the facility. Findings: During an observation on 12/16/2024 at 10:35 a.m., Resident 5 was observed walking in and out from different residents ' room at the facility, and there was no observation of a staff 1:1 sitter. During an observation on 12/17/2024 at 11:36 a.m., Resident 5 was observed walking throughout facility ' s hallway, and there was no observation of a staff 1:1 sitter. During a review of Resident 5 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the face Sheet indicated Resident 5 was admitted to the facility on [DATE]. Resident 5 ' diagnoses included dementia (a progressive state of decline in mental abilities), Alzheimer ' s Disease (a disease characterized by a progressive decline in mental abilities), depression (loss of interest in activities), and muscle weakness (loss of muscle strength). During a review of Resident 5 ' s Minimum Data Set (MDS - a resident assessment tool), dated 11/14/2024, the MDS indicated Resident 5 cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 5 required supervision or touching assistance (helper provides verbal cues and/or touching 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 5 ' s order summary report, dated 12/1/2024, the order summary report indicated Resident 5 needed a 1:1 sitter every shift with staff for safety. During a review of Resident 5 ' s care plan titled Impaired Coping, initiated 11/14/2024, the care plan interventions indicated the facility would provide 1:1 monitoring for safety. During a concurrent observation and interview on 12/19/2024 at 7:55 a.m., with Resident 5, Resident 5 was observed sitting in the wheelchair on the hallway. Resident 5 stated she did not know where her room was and there was no 1:1 sitter monitoring Resident 5. (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	12/19/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/19/2024 at 8:47 a.m., with Registered Nurse (RN 1) in the hallway, Resident 5 was observed walking in the hallway without 1:1 sitter monitoring. RN 1 stated Resident 5 was a wanderer and should have a 1:1 sitter for monitoring and safety. RN 1 stated Resident 5 wandering around and going in and out of other residents ' room was safety issue, and potential for invasion of privacy of other residents at the facility. During a review of the facility ' s policy and procedure (P&P) tilted Comprehensive Person-Centered Care Planning, revised 11/2018, the P&P indicated each resident will have a comprehensive care plan developed that includes goals, objectives, and interventions, and reflect best practice standards to meet the resident health, safety, and psychosocial needs. 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 each resident receives the necessary care and services, consistent with care plan to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

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	12/19/2024

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 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** 48343 Based on observation, interview and record review, the facility failed to provide one on one sitter ([1:1]-a single staff member is assigned to constantly observe and supervise a patient) as indicated in the resident care plan for one of three sampled residents (Resident 4). This deficient practice resulted Resident 4 falling, sustaining a laceration (a deep cut in the skin) on the forehead and had the potential to place Resident 4 at risk for recurrent falls. Findings: During a review of Resident 4 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the face Sheet indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 4 ' s diagnosis included Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4 ' s Minimum Data Set (MDS - a resident assessment tool), dated 10/29/2024, the MDS indicated Resident 4 cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 4 was dependent (helper does all 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 4 ' s care plan titled High risk for falls related to (r/t) gait/balance problems, initiated 12/12/2024, the care plan indicated the facility would provide 1:1 sitter for supervision and Resident 4 would be free of injury. During a review of Resident 4 ' s situation, background, assessment, recommendation ([SBAR]-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/13/2024, the SBAR indicated on 12/12/2024 Resident 4 slid out the bed and had a fall. The SBAR indicated Resident 4 sustained an irregularly shaped open wound on the forehead. During an on observation on 12/18/2024 at 8:00 a.m., in Resident 4 ' s room, Resident 4 was observed lying in bed, laceration on the forehead covered with bandage. During observation there was no 1:1 sitter monitoring Resident 4 at the bedside. During a concurrent observation and interview on 12/18/2024 at 8:15 a.m., with Certified Nursing Assistant (CNA 2), in Resident 4 ' s room. CNA 2 stated she was not Resident 4 ' s 1:1 sitter and she was not aware who should have been monitoring Resident 4. (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	12/19/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 12/18/2024 at 9:00 a.m., with CNA 3, CNA 3 was observed sitting on the chair in Resident 4 ' s room. CNA 3 stated he was Resident 4 ' s 1:1 sitter and was monitoring three other high fall risk residents in the same room (Resident 4 ' s room). CNA 3 stated one sitter assigned to 1:1 monitoring for four high fall risk residents was safety risk. CNA 3 stated he would not be able to prevent a resident fall because he was injured himself and was on light duty work (work that is less physically demanding). During an interview on 12/18/2024 at 9:47 a.m., with Director of Staff Development (DSD), the DSD stated Resident 4 required 1:1 sitter monitoring related to being a high fall risk. The DSD stated one staff member as a 1:1 sitter assigned for four high risk fall residents in the same room at the same time was a deficient practice. The DSD stated the facility failed to provide sufficient 1:1 sitter for Resident 4 and it resulted Resident 4 fall and injury. The DSD stated Resident 4 ' s fall could have been prevented if there was a 1:1 sitter for Resident 4. During a review of the facility ' s policy and procedure (P&P) titled Safety of Residents, revised 1/1/2012, the P&P indicated facility would provide a safe environment for residents. During a review of the facility ' s P&P titled Fall Management Program, revised 3/13/2021, the P&P indicated facility would provide residents a safe environment that minimizes complications with falls. During a review of the facility P&P titled Resident Rights- Quality of Life, revised 3/2017, the P&P indicated facility would ensure each resident receives the necessary care and services, consistent with care plan to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

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	12/19/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48343 Based on interview and record review, the facility failed to ensure the clinical records were maintained in accordance with accepted professional standards and complete the personal belongings inventory list for one of three sampled residents (Resident 1). This deficient practice resulted in incomplete medical records and misappropriation of Resident 1 ' s personal property. Findings: During a review of Resident 1 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident), the face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1 ' s diagnoses included Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizophrenia (a mental illness that is characterized by disturbances in thought), and Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1 ' s Minimum Data Set (MDS - a resident assessment tool), dated 12/16/2024, the MDS indicated Resident 1 cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching 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 1 ' s progress note, dated 12/3/2024, the progress note indicated Resident 1 was transferred to the general acute care hospital (GACH) for evaluation and treatment. The progress note indicated Resident 1 ' s belongings were kept in the facility. During a review of Resident 1 ' s progress note, dated 12/9/2024, the progress note indicated Resident 1 returned to the facility. During a concurrent observation and interview on 12/16/2024 at 10:33 a.m., in Resident 1 ' s room with Resident 1, was observed there were three boxes on the ground next to Resident 1 ' s bed. Resident 1 stated upon return to the facility from GACH he was transferred from his original room (room [ROOM NUMBER]) into the current room (room [ROOM NUMBER]) at the facility. Resident 1 stated facility transferred his personal belonging without his permission. Resident 1 stated he was missing eyeglasses, phone changer, and other personal belongings. Resident stated facility was not able to provide him with his personal belongings inventory list. Resident 1 stated facility was not helping him to locate his belongings. (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	12/19/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/2024 at 10:45 a.m., with Social Worker (SW), the SW stated residents ' personal belonging inventory list was completed upon admission, readmission and as needed when residents bring new personal staff into the facility. The SW stated Certified Nursing Assistant (CNAs) were responsible for completing residents ' belongings inventory list and placing it in the resident medical record chart. The SS stated was important for residents to have personal belongings inventory list at the facility for resident to know what belongings they have, and for staff to know if resident personal belongings would be loss or missed place facility. During a concurrent interview and record review on 12/16/2024 at 11:45 a.m., with CNA 1, CNA 1 stated it was CNAs responsibilities to complete Resident 1 ' s personal belonging inventory list upon GACH transfer and upon return to the facility. CNA 1 stated she was not able to provide a copy of Resident 1 ' s personal belonging inventory list because it was not done. During a review of the facility policy and procedure (P&P) titled Personal Property, revised 7/14/2017, the P&P indicated: a) Facility would ensure to protect resident ' s personal property. b) The P&P indicated the CNA/designee would conduct a resident ' s personal property inventory and place in the medical record. c) A copy of the written inventory shall be provided to the resident. d) A copy of a current inventory shall be made available upon request to the resident. e) The Interdisciplinary Team ([ITD]- a group of health care professionals to coordinate patient ' s care) would review the resident ' s inventory for accuracy quarterly, any would made changes or additions to the inventory.