STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/29/2024

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49906 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1), who had diagnoses including hypertension (HTN-high blood pressure), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (a mental health condition that involves a prolonged low mood or loss of interest in activities), anxiety (intense, excessive, and persistent worry and fear about everyday situations), and suicidal ideation (intrusive thoughts and preoccupation with death and dying), who was brought to the facility by the paramedics to be admitted on [DATE] at 9:50 p.m. was not left unattended, by failing to: 1. Provide Resident 1 with orientation of the facility. 2. Implement its policy and procedure (P&P) titled Resident Initial Admission Assessment which indicated, upon admission to the facility the licensed nursing staff would complete an initial admission assessment, identify the residents' needs and develop plans of care. 3. Implement its P&P titled Admission and Orientation of Residents, which indicated, the facility would only admit residents for whom they could provide adequate care. 4. Implement its P&P titled Admission and Orientation of Residents, which indicated, the admission coordinator/designee would notify the Director of Nursing (DON), upon a resident's arrival, promptly notify the physician, provide a Standard Admission Agreement, and create an admission record for the resident. 5. Ensure the DON assigned a licensed vocational nurse (LVN) to conduct Resident 1's initial assessment. 6. Provide activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) to Resident 1 for approximately 22 hours. 7. Assess and monitor Resident 1 who required mediations for diabetes, hypertension, depression, and anxiety. 8. Ensure there was adequate staffing to meet the needs of the residents. 9. Ensure staff were in-serviced on the admission process. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These failures resulted in Resident 1 calling 911 on 12/21/2024 at 7:30 p.m. (22 hours after arriving to the facility) to be transferred back to a general acute care hospital (GACH) for further evaluation and treatment. On 12/27/2024 at 6:20 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Director of Staff Development (DSD) due to the facility's failure of not providing the appropriate care and services to Resident 1 such as orientation to the facility, completing an initial admission record, assessing/monitoring the needs of the resident, identifying care needs and developing a plan of care. On 12/29/2024 at 4:58 p.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After verification of the IJRP implementation through observation, interview, and record review, the IJ was removed on 12/29/2024 at 5:40 p.m., in the presence of the facility's Senior Regional Quality Management Consultant (RQMC). The IJRP included the following immediate actions: 1. On 12/27/24, beginning on the 3-11 p.m. shift through the 12/28/2024 3-11 p.m. shift, the DSD/designee initiated immediate education to Licensed Nurses, certified nursing assistants (CNAs) on every shift and Department Managers on the following facility's policies and procedures: a. Resident Initial Admission Assessment- with emphasis on completing an initial admission assessment, identifying the resident's needs and documentation in the resident's medical record. b. Admission and Orientation of Residents- with emphasis the admission coordinator/designee will notify the DON upon a resident's arrival, promptly notify the physician, provide a Standard Admission Agreement, and create an admission record for the resident. Also, a review of the admission process for direct care staff. c. Admission Criteria- with emphasis on admitting Residents who meet the criteria for adequate care within the facility. 2. The DON will assign an LVN to conduct the initial assessment of new residents. 3. The facility will attempt to replace the nursing staff who called off from their scheduled shift by calling other nursing staff who are not scheduled and are available to work, including licensed department managers, to ensure adequate staffing. 4. Staff were in-serviced on the new admission process beginning on 12/29/2024 3-11 p.m. shift by the DSD. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including HTN, DM, depression, anxiety, and suicidal ideation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's Census Report dated 12/20/2024, the Census Report indicated 95 residents were listed in the facility. During a review of Resident 1's History and Physical (H&P) from the transferring hospital (GACH 1), dated 12/12/2024, the H&P indicated Resident 1 could answer all questions appropriately. During a review of the facility's Nursing Assignment Sheet, dated 12/20/2024 (no time specified), the Nursing Assignment Sheet indicated there were three LVN Charge Nurses scheduled to work the 3 p.m. - 11 p.m. shift. The Nursing Assignment Sheet indicated one LVN called off (did not work). During a review of the Los Angeles City Fire Department (LAFD) report titled LAFD Patient Care Report, dated 12/21/2024, the LAFD report indicated on 12/21/2024 at 7:37 p.m., Resident 1 was transported to GACH 2 with chief complaints of weakness and dizziness for 24 hours and diabetic problem. The report indicated on 12/21/2024, at 7:16 p.m. Resident 1's blood pressure (BP) was 195/91 millimeters of mercury ([mmHg] unit of measurement, normal BP is less than 120 over less than 80 mmHg), heart rate (HR) 74 beats per minute (bpm, normal HR is between 60-100 bpm), respiratory rate (RR) of 14 breaths per minute (normal RR 12-20 breaths per minutes), oxygen saturation level (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) of 97 percent (%) (normal oxygen saturation 93-100%) and blood sugar (BS) level of 240 milligrams per deciliter ([mg/dl] a unit of measurement, normal blood glucose level is 70-100 mg/dl). The LAFD report indicated Resident 1 was in mild distress. The LAFD report indicated Resident 1 stated she was admitted to the facility approximately 24 hours ago after being discharged from GACH 1. The LAFD report indicated Resident 1 stated she was denied her routine medications like insulin (medicine for diabetes) and hypertensives (medicine to treat HTN) in the 24 hours while at the facility. The LAFD report indicated when the emergency medical service (EMS- a system that provides emergency medical care) staff asked the facility staff (staff not identified) why Resident 1 did not receive her medications, the staff became unprofessional and confrontational, raised his voice at the EMS staff and Resident 1's family member (FM 1) and walked away. During a review of Resident 1's GACH 2 records, titled Emergency Documentation (ED), dated 12/23/2024 at 9:31 p.m., the notes indicated Resident 1 presented to the ED with altered level of consciousness (a change in a person's state of awareness and alertness) and mild confusion. The ED notes indicated Resident 1 had elevated liver enzymes (sign of inflamed or damaged cells in the liver) and hyponatremia (a condition where the level of sodium in the blood is too low). The notes indicated Resident 1 was given fluids for hydration and one gram (g, unit of measurement) of sodium chloride tablet (medicine to elevate sodium level). Resident 1 was admitted to the GACH 2's Telemetry unit (a floor in a hospital where patients undergo continuous cardiac monitoring) for further monitoring. During a telephone interview on 12/26/2024 at 2:10 p.m. with LAFD Paramedic 1 (LAFDP 1), LAFDP 1 stated on 12/21/2024 at 6:56 p.m., he and another paramedic personnel responded to the call from Resident 1's FM 1. LAFDP 1 stated FM 1 reported that Resident 1, who was at the facility, did not receive medications nor had a diaper change. LAFDP 1 stated upon arrival at the facility, An unidentified male staff member was confrontational. LAFDP 1 stated he assessed Resident 1 and transported her (Resident 1) to GACH 2 per the resident's request. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/26/2024 at 4:50 p.m., with LVN 1, LVN 1 stated Registered Nurse (RN) 1 informed her (LVN 1) of Resident 1's pending arrival at the beginning of the 3 -11 p.m., shift on 12/20/2024. LVN 1 stated RN 1 relayed the report RN 1 received about Resident 1 from GACH 1. LVN 1 stated Resident 1 arrived at the facility on 12/20/2024 at 10 p.m. LVN 1 stated Resident 1 was not oriented to the facility and there was no initial resident assessment done for Resident 1. LVN 1 stated she left Resident 1's the initial assessment for the in-coming 11 p.m. - 7 a.m. LVN to complete it because she (LVN 1) did not know how to do an initial assessment. LVN 1 stated she did not notify any physician that Resident 1 was in the facility for admission orders. LVN 1 stated no medications were ordered for the resident, and she (LVN 1) did not document anything in Resident 1's Electronic Health Records (EHR) because she did nothing for the resident and there was nothing for her to document. LVN 1 stated the nurse for the incoming 11p.m. - 7 a.m. shift on 12/20/2024 called off. LVN 1 stated she continued to work from 11 p.m. on 12/20/2024 until 7 a.m. on 12/21/2024 because the facility was short staffed and had no one to replace her. LVN 1 stated she did not offer Resident 1 anything to eat or drink and did not know if any staff did. LVN 1 stated there was only one other LVN (LVN 3) who worked the 11 p.m.- 7 a.m., shift on 12/20/2024. LVN 1 stated she checked Resident 1's blood sugar level but did not document it. LVN 1 stated Resident 1 had two visitors during that evening (time unknown) on 12/21/2024. LVN 1 stated one of the visitors asked LVN 1 multiple times why Resident 1 did not receive any medications since her arrival to the facility. LVN 1 stated she called LVN 4 on the telephone for assistance and LVN 4 told LVN 1, she would send an RN to assist because LVN 1 did not know how to complete an admission and never received training. LVN 1 stated the visitor was very upset and called 911 stating he wanted Resident 1 to go back to the GACH. During a concurrent interview and record review on 12/27/2024 at 4:12 p.m. with RN 1, a handwritten report titled Admission Report dated 12/20/2024 at 2:53 p.m., signed by RN 1, was reviewed. RN 1 stated on 12/20/2024 at 2:53 p.m., RN 1 received a report from a RN at GACH 1 regarding Resident 1 being transferred to the facility. RN 1 stated the handwritten report indicated Resident 1 had diagnoses of hyponatremia (low sodium level), HTN, and stroke (a medical emergency that occurs when blood flow to the brain is disrupted). RN 1 stated the report indicated Resident 1 was to receive a regular, carbohydrate controlled (CCHO, meal plan that involves eating a consistent amount of carbohydrates each day) diet. The handwritten report indicated Resident 1's latest untimed vital signs (measurements of the body's basic functions, such as temperature, breathing rate, blood pressure, and pulse rate), were as follows BP 148/72 mmHg, HR 70, Temperature 36.9 degrees Fahrenheit (F, measurement of temperature), RR 16, O2 sat 96%, and a BS level of 217. RN 1 stated she gave a copy to LVN 1 and the kitchen, indicating Resident 1's diet order from the hospital, before creating a paper chart for Resident 1. During a telephone interview on 12/28/2024 at 10:17 a.m. with Resident 1's Emergency Contact (EC) provided on the admission sheet, the EC stated he visited Resident 1 at the facility on 12/21/2024 around 5:00 p.m., accompanied by his assistant. The EC stated Resident 1 was sitting on the bed with feces (the material in a bowel movement) soiling the sheet and her gown. The EC stated Resident 1 told him she (Resident 1) was in pain and had not received pain medicine or insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). The EC stated he spoke to LVN 1, who called LVN 4 and was told by LVN 4 she would send a RN to assist in entering orders and administering Resident 1's medications. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/28/2024 at 5 p.m., with the DSD, the DSD stated she had not in-serviced staff on the admission process in 2 years. The DSD stated she was not aware if all licensed staff knew what to do when a resident was to be admitted to the facility. The DSD stated the facility did not have any staffing agency to use in case of staffing shortage. During an interview on 12/28/2024 at 5:46 p.m., LVN 4 stated LVN 1 called her (LVN 4) regarding EC's concern that Resident 1 had not received any medications or care since arriving to the facility on [DATE]. LVN 4 stated she tried to find another staff to assist the LVN 1 and LVN 4 on 12/21/2024 3:00 p.m. - 11:00 p.m. but was unsuccessful. LVN 1 stated the facility did not have any staffing registry. LVN 1 stated the Director of Nursing (DON) was on vacation. During a review of the facility's undated Job Description titled, Director of Staff Development Job Description, the job description indicated the DSD was responsible for coordinating and conducting an effective on-going in-service plan to all employees. During a review of the facility's undated Job Description titled, Charge Nurse, the job description indicated the charge nurse will assume responsibility and oversight of an assigned nursing unit including assignment and coordination of nursing care. The job description indicated the charge nurse will coordinate resident admissions, transfers, and discharges. During a review of the facility's P&P titled, Admission and Orientation of Residents, dated 10/2017, the P&P indicated when a new resident arrives at the facility, the facility will promptly notify the resident's attending physician of the resident's admission to the facility. The P&P indicated, upon admission, the resident's attending physician will provide the order for skilled nursing care, the type of diet the resident requires, medication orders, including a medical condition or problem associated with each medication and routine care orders to maintain or improve the resident's function. The P&P indicated, the Director of Nursing will assign a LVN to conduct the initial assessment of the resident and prepare the chart for admission. The P&P indicated, the LVN will document the initial assessment in the resident's medical records and initiate the relevant care plan for the resident. During a review of the facility's P&P titled, Resident Initial Admission Assessment, dated 3/23/2023, the P&P indicated the licensed nursing staff will complete an initial admission assessment upon admission to the facility to identify the residents' needs and develop plans of care. The P&P indicated the assessment will be documented in the medical record.