

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 02/13/2025
NAME OF PROVIDER OR SUPPLIER East Terrace Rehabilitation & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Implement its policy and procedures (P&P), for one of 5 sampled residents. (Resident 3). <p>This deficient practice resulted in Resident 3 sustaining unknown bruises and skin tears.</p> <p>Findings:</p> <p>During a review of Resident 3's face sheet, indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection (UTI- an infection in the bladder/urinary tract), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/14/2024, the MDS Section C, indicated Resident 3 ' s cognitive skills was severely impaired. The MDS Section GG also indicated Resident 3 required supervision with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing.</p> <p>During a review of Resident 3's nursing progress notes, dated 12/7/2024, the nursing progress notes indicated Resident 3 had light greenish skin discoloration to the left hip.</p> <p>During a review of Resident 3 ' s skin assessment, dated 12/22/2024, the skin assessment indicated Resident 3 had a skin tear (a wound that occurs when the skin layers separate, often due to blunt force or friction) on her front left shoulder and left elbow.</p> <p>During a review of Resident 3 ' s care plan, dated 12/30/2024, the care plan indicated Resident 3 had skin discoloration to her left arm and right upper thigh.</p> <p>During a review of Resident 3 ' s change of condition form, dated 12/30/24, the change of condition form indicated Resident 3 had light purple-yellowish skin discoloration around her left elbow and on her right buttock.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, on 02/13/2025, at 1:21 p.m., with the Director of Nursing (DON), the DON stated the protocol for injury of unknown origin was to report to the facility ' s ombudsman, law enforcement and California Department of Public Health within 2 hours. The DON stated she was aware of Resident 3's skin discoloration to her left hip, left elbow and right buttock. The DON stated she was not aware of Resident 3's skin tears and other areas of discoloration. The DON stated the policy was not implemented or followed. The DON stated the facility did not report Resident 3's skin tears and skin discoloration to the appropriate agencies. The DON stated the risk of not following the facility ' s policy and procedures could result in possible abuse and safety issues.</p> <p>During a review of the facility's policy and procedures, titled Abuse Prevention and Management revised 5/30/2024, indicated When the Administrator or designated representative receives a report of an allegation of resident abuse, mistreatment, neglect, abuse facilitated or enabled by technology, exploitation or injuries of an unknown source, or suspicion of a crime, the Administrator or designated representative, will initiate an investigation immediately.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46832</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> Investigate all areas of skin discoloration (a change in the color, texture, or pigmentation of the skin) and skin tears for one of five sampled residents (Resident 3). <p>This deficient practice had the potential to place Resident 3 and other vulnerable residents at increased risk of abuse.</p> <p>Findings:</p> <p>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 admitted to the facility on [DATE] with diagnoses which included urinary tract infection (UTI- an infection in the bladder/urinary tract), Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities) and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality).</p> <p>During a review of Resident 3 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/14/2024, the MDS Section C, indicated Resident 3 ' s cognitive skills was severely impaired. The MDS Section GG also indicated Resident 3 required supervision with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting needs, showering and upper/lower body dressing.</p> <p>During a review of Resident 3 ' s nursing progress notes, dated 12/7/2024, the nursing progress notes indicated Resident 3 had a light greenish skin discoloration on left hip.</p> <p>During a review of Resident 3 ' s skin assessment, dated 12/22/2024, the skin assessment indicated Resident 3 had a skin tear (a wound that occurs when the skin layers separate, often due to blunt force or friction) on her front left shoulder and left elbow.</p> <p>During a review of Resident 3 ' s care plan, dated 12/30/2024, the care plan indicated Resident 3 had skin discoloration on her left arm and right upper thigh.</p> <p>During a review of Resident 3 ' s change of condition (COC- a significant change in a person's physical or mental health) form, dated 12/30/24, the change of condition form indicated Resident 3 had light purple-yellowish skin discoloration around her left elbow and on her right buttock.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on 02/12/2025, at 12:02 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated investigate reports were completed if a resident had multiple falls, unexplainable skin discoloration, and unknown or unusual injuries. LVN 1 stated she was aware of Resident 3 ' s skin discoloration on her left hip and skin tear on her left elbow. LVN 1 stated she was not aware of the other areas of Resident 3 ' s skin discoloration. LVN 1 stated the facility should had initiated a risk management assessment and investigation report for all areas of Resident 3 ' s skin discoloration. LVN 1 stated the facility did not document any evidence of an investigation for Resident 3 ' s skin tears and skin discoloration. LVN 1 stated the risk of not completing an investigation report for skin tears and skin discoloration could result in a delay of care and/or potential abuse.</p> <p>During a concurrent interview and record review, on 02/13/2025, at 12:57 p.m., with Registered Nurse 1 (RN 1), RN 1 stated she was not aware of Resident 3 ' s skin discoloration. RN 1 stated unusual skin discoloration and skin tears was required to be investigated by the facility. RN 1 stated the facility did not conduct investigations for Resident 3 ' s skin tears and skin discoloration. RN 1 stated the risk of not investigating Resident 3 ' s skin tears and skin discoloration origin could result in skin breakdown and possible abuse.</p> <p>During an interview, on 02/13/2025, at 1:21 p.m., with the Director of Nursing (DON), the DON stated the protocol for skin discoloration required the facility to complete a risk management assessment and conduct a thorough investigation to determine the root cause of the origin. The DON stated she was aware of Resident 3 ' s skin discoloration to her left hip, left elbow and right buttock. The DON stated she could not recall if the facility investigated Resident 3 ' s skin tears and discoloration. The DON stated, I don ' t think we did. The DON stated the risk of the facility failing to complete an investigation report for Resident 3 ' s skin tears and skin discoloration could result in not knowing what happened to the resident and potential abuse.</p> <p>During a review of the facility ' s policy and procedures, titled Unusual Occurrence Reporting, dated 6/12/2024, indicated, The facility conducts and documents timely and thorough investigations into all unusual occurrences and takes corrective action as appropriate. The investigation and documentation should include but is not limited to: a. Interviews with residents, staff, and any other witnesses. B. Review of the facility records; and/or c. Audits of a service/system. and The facility maintains copies of incident reports of any unusual occurrences for at least one (1) year.</p> <p>During a review of the facility ' s policy and procedures, titled Abuse Prevention and Management revised 5/30/2024, indicated When the Administrator or designated representative receives a report of an allegation of resident abuse, mistreatment, neglect, abuse facilitated or enabled by technology, exploitation or injuries of an unknown source, or suspicion of a crime, the Administrator or designated representative, will initiate an investigation immediately.</p>		