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	04/09/2025

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 - 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** 50379 Based on interview and record review the facility failed to provide a two-person assist (one on each side of the bed) for one of three sampled residents (Resident 1), who was dependent on staff for turning and repositioning. Certified Nurse Assistants (CNA 1 and CNA 2) repositioned Resident 1 while both were standing on the left side of the resident's bed. This failure resulted in Resident 1 falling onto the floor, sustaining a femur (thigh bone) fracture (broken bone) experiencing pain and fear, and was transferred to a general acute care hospital (GACH) for evaluation and treatment. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. The Admission Record indicated Resident 1's diagnoses included morbid (severe) obesity (excessive fat accumulation), bilateral (both sides) osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the knee, chronic pain syndrome (condition of persistent pain, muscle weakness and unspecified lack of coordination (problem with movement, balance or coordination). During a review of the Facility's In-Service (training or education) Meeting titled, Repositioning, Turning dated 1/16/2024, the In-Service indicated CNAs were trained on the procedures to follow when turning and repositioning residents who could not assist and ensuring safety of residents when turning/repositioning. The In-Service lesson plan indicated; CNAs were to perform the procedure (turning/repositioning) positioned on opposite sides of the bed. The In-Service sign-in indicated CNA 1 and CNA 2 attended the In-Service. During a review of Resident 1's History and Physical (H&P) dated 2/13/2025, the H&P indicated Resident 1 had the capacity to understand and make medical decisions. The H&P indicated Resident had a history of paraplegia (paralysis of the legs and lower body) and was bedridden. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Care Plan titled The resident has an ADL self-care performance deficit related to impaired balance and limited mobility dated 2/28/2024, the Care Plan indicated Resident 1 had an Activities of Daily Living, Self-care Performance Deficit related to Impaired Balance and Limited Mobility. The Care Plan Indicated Resident 1 was totally dependent (staff does all the effort, resident does none of the effort to complete the activity or requires two or more staff to complete the activity). The nursing interventions indicated Resident 1 required two staff assistance to turn and reposition the resident in bed. During a review of Resident 1's Minimal Data Set (MDS - a resident assessment tool) dated 3/13/2025, the MDS indicated Resident 1 had no cognitive (ability to think and reason) impairment The MDS indicated Resident 1 was dependent on staff for ADLs such as dressing, personal hygiene and bed mobility (the ability to roll from lying on back to left and right side, and return to lying back on the bed). During a review of Resident 1's Care Plan titled Documented Safety Concerns dated 3/13/2025, the Care Plan goals indicated Resident would remain safe. The Care Plan nursing intervention was to provide safety measures including strategies to reduce the risk of falls and injury. During a review of Resident 1's Change of Condition (COC), dated 3/20/2025, the COC indicated Resident 1 had a witnessed fall on 3/20/2025. The COC indicated Resident 1 sustained a skin tear (unspecified location) and a had pain level of 8 out 10 (pain rating reference 1-3 mild pain; 4-6 moderate pain, 7-10 severe pain) of the right leg/foot. The COC indicated Resident 1 weighed 501.8 pounds ([lbs]unit of measurement). During a review of Resident 1's Progress Note, dated 3/20/2025, the Progress Note indicated Resident 1 slipped out of bed and fell . The Progress Note indicated Resident 1 had an avulsion (tearing of skin from the body) to the right great (big) toe, and a skin tear to posterior (backside of) left knee. During a review of Resident 1's Physician Orders, dated 3/20/2025, the Physician Orders indicated stat (urgent) x-ray (process of taking pictures of the inside of your body to help diagnose conditions or injuries) to the right lower extremity (leg) including right foot to transfer and to transfer Resident 1 to a GACH. During a review of Resident 1's GACH Orthopedic (medical specialty focused on injuries and diseases affecting the musculoskeletal system [bones, muscles, joints and soft tissues]) Surgery Consult H&P dated 3/23/2025, the H&P indicated Resident 1 was admitted for evaluation of a right leg pain. The H&P indicated based on Resident 1's weight, shape of her legs and feet, the resident was unable to stand or walk. The H&P indicated the Resident 1's family (FM 1) reported Resident 1 was dropped by the facility's nursing staff when the staff tried to roll the resident. The H&P indicated Resident 1 of pain (unrated), to the right leg and she had a displaced fracture of the right distal femur. During an interview on 4/8/2025 at 8:33 a.m. with Resident 1, Resident 1 stated on 3/20/2025 (time unknown), she fell off the right side of the bed when CNAs 1 and 2 were trying to turn her in bed during care, while standing on the left side of the resident's bed. Resident 1 stated no staff members were present at the right side of the bed when CNA 1 and 2 were turning and repositioning her. Resident 1 stated after she fell , she was so scared and experienced excruciating right leg pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/9/2025 at 8:40 a.m. with CNA 1, CNA 1 stated Resident 1 was dependent on staff to turn and move in bed. CNA 1 stated during Resident 1's ADL care, Resident 1 was lying at the edge of the right side of the bed, while she (CNA 1) and CNA 2 were both standing on the left side of the resident's bed. CNA 1 stated, when she (CNA 1) and CNA 2 pulled Resident 1's draw sheet (a sheet placed across the middle of the bed to facilitate repositioning and moving the resident) towards them, to move the resident to the middle of the bed, Resident 1 fell off the right side of the bed. CNA 1 stated it was not safe for both staff members to be on the left side of the bed, while turning Resident 1 to the opposite direction. CNA 1 stated one of the CNAs (CNA 1 or CNA 2) should have stood on the right side of the bed to secure Resident 1 and prevent the resident from falling and sustaining an injury. During an interview on 4/9/2025 at 11:35 a.m., with the Director of Staff Development (DSD), the DSD stated, CNAs have been in-serviced on ADL care, repositioning residents in bed with emphasis on ensuring there was at least one staff member on each side of the bed when turning and cleaning dependent residents such as Resident 1. During an interview on 4/9/2025 at 12:40 p.m., with CNA 2, CNA 2 stated she (CNA) and CNA 2 were standing on the left side of the bed when Resident 1 fell (on the right side of the bed). CNA 2 stated this technique was not safe. CNA 2 stated Resident 1's fall could have been prevented if safe techniques were used and one of them (CNA 1 or CNA 2) stood on the right side of Resident 1's bed when the resident was repositioned. During a concurrent interview and record review on 4/9/2025 at 3:10 p.m. with the Director of Nursing (DON), Resident 1's IDT Note, dated 3/25/2025 was reviewed. The DON stated the IDT Note indicated two CNAs were standing on the left side of the bed while they turned and cleaned Resident 1. The DON stated no staff were present on the right side of the bed when Resident 1 fell out of the bed. The DON stated the CNAs were unsafe and at least one staff member should have been on each side of the bed to prevent falls. The DON stated staff's unsafe patient handling resulted in Resident 1's fall and injury. The DON stated Resident 1's fall on 3/20/2025 resulted in femur fracture, severe pain, and hospitalization . During an interview on 4/16/2025 at 2:50 p.m., with the Orthopedic Physician (Ortho), the Ortho stated, Resident 1 sustained an acute (new) fracture of the distal femur (lower end of the thigh bone) close to the knee. The Ortho stated Resident 1's fracture was caused by a traumatic mechanism from the fall and was very painful. The Ortho stated the fracture was inoperable due to Resident 1's large size and being bedbound (someone who is confined to the bed). During a review of the facility's Policy and Procedure (P&P) titled, Fall Management Program dated 3/13/2021, the P&P indicated the purpose of facility's Fall Management program was to provide residents a safe environment that minimized complications with falls. The P&P indicated the facility will implement a fall management program that supported providing an environment free from fall hazards.