

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 09/05/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an unwitnessed fall with injury for one out of three sampled residents (Resident 7) to California Department of Public Health (CDPH). This deficient practice caused a delay in an investigation of a fall with injury by CDPH. Findings: During a review of Resident 7's admission Record, dated 9/3/2025, the admission Record indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses of polyarthritis (the inflammation or involvement of five or more joints as the same time), muscle weakness (a reduction in muscle strength, affecting patient's ability to maintain mobility), and difficulty in walking (a patient's has limitation/ability to move independently affecting their walking). During a review of Resident 7's History and Physical (H&P), dated 7/24/2025, the H&P indicated Resident 7 could make needs known but could not make medical decisions. During a review of Resident 7's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 8/27/25, the MDS indicated Resident 7's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 7 required partial/moderate assistance (helper does more than half the effort) for toileting hygiene, showers, and putting on footwear. The MDS indicated Resident 7 had a fall in the last two to six months prior to admission/entry or reentry to the facility. During a review of Resident 7's Situation Background Assessment and Recommendation (SBAR), dated 8/16/2025, the SBAR indicated Resident 7 had an unwitnessed fall. The SBAR indicated the Certified Nurse Assistant (CNA) found Resident 1 sitting on the floor in the resident's room with a big bump on her right forehead. The SBAR indicated to transfer Resident 1 to the hospital for further evaluation. During a review of Resident 7's physician order titled, Order Summary Report, dated 8/22/2025, the physician order indicated to monitor for skin breakdown of the hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel)/bump on the right side of forehead daily. During an interview on 9/3/2025 at 3:51 p.m., with the Administrator (ADM), the ADM stated he was not aware that the Resident 7 fell and had a bump on her forehead. The ADM stated an unwitnessed fall was considered an unusual occurrence and staff were mandated reporters. The ADM stated unusual occurrences had to be reported to CDPH so the fall could be investigated and to ensure the interventions were implemented to improve Resident 7's care and safety. During a concurrent interview and record review on 9/3/2025 at 4:19 p.m. with the Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled, Unusual Occurrence Reporting, dated 6/2024, was reviewed. The P&P indicated the facility would report allegations of abuse and unusual occurrences that affect the welfare, health, or safety of residents by phone and in writing to the appropriate State or Federal agencies within 24 hours. The ADON stated Resident 7 had an unwitnessed fall with a bump on her head. The ADON stated per policy, the unwitnessed fall with injury should have been reported within 24 hours of the incident. The ADON stated the purpose of reporting within 24 hours to avoid and prevent further falls. During a review of the facility's P&P titled, Abuse Prevention and Management, dated 6/12/2024, the P&P indicated the definition of abuse included injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish. During a review the facility's P&P titled, Unusual Occurrence Reporting, dated 6/2024 was reviewed. The P&P indicated the facility would report allegations of abuse and unusual occurrences that affect the welfare, health, or safety of residents by phone and in writing to the appropriate State or Federal agencies within 24 hours.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one out of three sampled residents (Resident 1) had a care plan after an injury to his right hand. This deficient practice had the potential to place Resident 1 at risk for infection and worsening of the injury to the right hand. Findings: During a review of Resident 1's admission Record, dated 9/3/2025, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), depression (a persistent mood disorder characterized by sadness and a loss of interest), and anxiety (a feeling of apprehension, fear, or dread in response to a real or perceived threat). During a review of Resident 1's History and Physical (H&P), dated 7/31/2025, the H&P indicated Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Sheet ([MDS]- a resident assessment tool), dated 7/4/2025, the MDS indicated Resident 1's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showers, and putting on footwear. During a review of Resident 1's physician orders titled, Order Summary Report, dated 8/30/2025, the physician orders indicated to cleanse right inner thumb cleanse with normal saline (an isotonic, sterile solution of sodium chloride [salt] in water), pat dry, and paint with betadine leave open to air daily for 7 days. During an observation on 9/3/2025 at 9:30 a.m. in Resident 1's room, Resident 1's right hand had stitches between the right thumb and index finger (second finger). During a concurrent interview and record review on 9/4/2025 at 10:38 a.m. with Treatment Nurse (TN) 1, Resident 1's care plans were reviewed. TN 1 stated there were no care plans or interventions for the sutures (a row of stitches holding together the edges of a wound) on Resident 1's right hand. TN 1 stated the care plan would set goals and interventions to maintain the care of the sutures. TN 1 stated without the proper interventions and goals, Resident 1 could get an infection to the right hand. During an interview on 9/4/2025 at 10:45 a.m., with Registered Nurse (RN) 1, RN 1 stated having a care plan was important to make sure interventions, such as dressing changes, medications or monitoring for signs of infection, were being followed daily. RN 1 stated the goal for Resident 1's care plan would be to prevent infection. During a review of the facility's policy and procedures (P&P) titled, Comprehensive Person-Centered Care Planning, dated 11/2018, the P&P indicated to ensure a comprehensive person-centered care plan was developed for each resident. The P&P indicated the care plan must reflect the resident's stated goals and objectives and include interventions that address their other needs.</p>		