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	01/28/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report an injury of unknown source (injury of unknown source when all of the following criteria are met: the source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury [e.g., the injury is located in an area not generally vulnerable to trauma]) for one of five sampled residents (Resident 1).This failure delayed the investigation by the California Department of Public Health (CDPH) and placed Resident 1 at risk for abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish).Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included Chronic Obstructive Pulmonary Disease ([COPD], a chronic lung disease causing difficulty in breathing) and generalized (affecting throughout the body) muscle weakness. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 12/19/2025, the MDS indicated Resident 1 had moderate (not extreme) cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 was dependent (helper does all the effort) with Activities of Daily Living (ADLs) such as toileting and personal hygiene. The MDS indicated Resident 1 was dependent with staff in rolling from a lying on back position to her left and right side, from sitting to lying position, lying to sitting on side of bed and sitting to standing position. During a concurrent observation and interview on 1/23/2026 at 12:08 p.m. with Resident 1, Resident 1 had yellowish- purplish skin discoloration (any change to the skin's natural color) on her left dorsal hand. Resident 1 stated it (discoloration) happened after someone (unnamed) took her blood pressure (BP) too tight (could not recall when) in the left hand. During an interview on 1/23/2026 at 2:59 p.m., with the Treatment Licensed Vocational Nurse (LVN), the Treatment LVN stated that she first identified redness on Resident 1's left dorsal hand on 1/2/2026 due to a blood pressure (BP) cuff being too tight. Treatment LVN stated that Resident 1, at the time of interview, could not provide when or who did it. The Treatment LVN stated on 1/21/2026, she reassessed Resident 1's left dorsal hand redness but did not document in the resident's progress notes. The Treatment Nurse stated the Wound Physician (MD) examined Resident 1's left dorsal hand on 1/23/2026 as ecchymosis (a type of bruise caused by blood leaking from broken blood vessels into the skin, resulting in a flat, discolored patch). During a concurrent interview and record review on 1/27/2026 at 12:19 p.m., with Certified Nursing Assistant (CNA) 1, Resident 1's left dorsal hand picture taken 1/23/2026 was reviewed. CNA 1 stated Resident 1's left dorsal hand picture taken on 1/23/2026 was like Resident 1's skin color (yellowish-purplish color) she observed on 1/21/2026. CNA 1 stated on 1/21/2026, she (CNA 1) notified LVN 2 about the yellowish-purplish skin discoloration of Resident 1's left dorsal hand. During an interview on (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/27/2026 at 2:04 p.m., with LVN 2, LVN 2 stated that if any staff reported discoloration on a resident's skin, the LVN should notify the Director of Nursing (DON) and Administrator (Admin) for investigation because of the possibility of abuse. During a concurrent interview and record review on 1/28/2026 at 12:28 p.m., with LVN 2, a picture of Resident 1's left dorsal hand taken 1/23/2026 and MD orders were reviewed. LVN 2 stated the bruise seen in the picture on Resident 1's hand was not there last week (date not specified). LVN 2 stated that if the skin was red and became discolored, it could be from an unknown origin. LVN 2 stated a change of condition (COC) should have been created. LVN 2 stated if an injury of unknown origin is not reported, it could delay the care the residents need and safety could be affected. LVN 2 stated Resident 1's physician orders did not indicated she was on any blood thinners (medication that prevents clots from forming, which could lead for bruises to easily form) which could cause easy bruising. During an interview on 1/28/2026 at 1:32 p.m., with the Treatment LVN, the Treatment LVN stated ecchymosis can be an injury of unknown origin and should have been reported to CDPH because of the possibility that Resident 1 was injured by a staff. During an interview on 1/28/2026 at 3:12 p.m., with the DON, the DON stated if a staff saw residents with skin discolorations, the Charge Nurse should assess the resident, ask the resident how it happened, create a COC assessment and notify the MD. The DON stated if the skin discoloration was an injury of unknown origin, the facility must know how it happened and should be reported to the CDPH. During an interview on 1/28/2026 at 4:03 p.m., with the Administrator (Admin), the Admin stated he was not aware of the unexplained bruising of Resident 1. The Admin stated an injury of unknown origin is when the facility is not sure how the injury happened. The Admin stated, we determined how it happened by doing an investigation and asking the resident. The Admin stated if it was brought to his attention, staff would have investigated and assess the bruising to determine where it came from to rule out abuse. If it came out as an alleged abuse, the facility would report it to CDPH. The Admin stated if we conclude it's not abuse, it's not reportable to CDPH. During a review of facility's policy and procedure (P&P) titled, Abuse Prevention and Management, dated 6/12/2024, the P&P defined Injury of Unknown Source as, an injury that meets both of the following conditions: the source of the injury was not observed by any person, and the injury is suspicious because of the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma). The P&P indicated to notify CDPH Licensing and Certification by telephone immediately, or as soon as practicably possible, but no longer than two (2) hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to investigate an injury of unknown source (injury of unknown source when all of the following criteria are met: the source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury [e.g., the injury is located in an area not generally vulnerable to trauma]) when one of five sampled residents' (Resident 1) left dorsal hand (back of hand) had yellowish-purplish skin discoloration on 1/21/2026 and ecchymosis (a type of bruise caused by blood leaking from broken blood vessels into the skin, resulting in a flat, discolored patch) on 1/23/2026. This failure placed Resident 1 at risk for severe injuries, including hospitalization and death. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included Chronic Obstructive Pulmonary Disease ([COPD], a chronic lung disease causing difficulty in breathing) and generalized (affecting throughout the body) muscle weakness. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 12/19/2025, the MDS indicated Resident 1 had moderate (not extreme) cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 was dependent (helper does all the effort) with Activities of Daily Living (ADLs) such as toileting and personal hygiene. The MDS indicated Resident 1 was dependent with staff in rolling from a lying on back position to her left and right side, from sitting to lying position, lying to sitting on side of bed and sitting to standing position. During a review of Resident 1's progress notes from 1/21/2026 to 1/23/2026, the progress notes did not indicate Resident 1's left dorsal hand yellowish-purplish skin discoloration on 1/21/2026 and the ecchymosis on 1/23/2026, were investigated. During a concurrent observation and interview on 1/23/2026 at 12:08 p.m. with Resident 1, Resident 1 had yellowish- purplish skin discoloration on her left dorsal hand (back of hand). Resident 1 stated it (discoloration) happened after someone (unnamed) took her blood pressure (BP) too tight (could not recall when) in the left hand. During a concurrent interview and record review on 1/23/2026 at 2:59 p.m., with the Treatment License Vocational Nurse (LVN), Resident 1's Skin Check notes dated 1/23/2026, were reviewed. The Treatment LVN stated on 1/23/2026, the Wound physician (MD) saw Resident 1's left dorsal hand had ecchymosis. During a concurrent interview and record review on 1/27/2026 at 12:19 p.m., with Certified Nursing Assistant (CNA) 1, Resident 1's left dorsal hand picture taken 1/23/2026 was reviewed. CNA 1 stated Resident 1's left dorsal hand picture taken on 1/23/2026 was like Resident 1's skin color (yellowish-purplish color) she observed on 1/21/2026. CNA 1 stated on 1/21/2026, she (CNA 1) notified LVN 2 about the yellowish-purplish skin discoloration of Resident 1's left dorsal hand. During an interview on 1/27/2026 at 2:04 p.m., with LVN 2, LVN 2 stated that if any staff reported discoloration on a resident's skin, the LVN should notify the Director of Nursing (DON) and Administrator (Admin) for investigation because of the possibility of abuse. During an interview on 1/28/2026 at 3:12 p.m., with the DON, the DON stated if a staff saw residents with skin discolorations, the Charge Nurse should assess the resident, ask the resident how it happened, create a Change of Condition (COC) assessment and notify the MD. The DON stated if the skin discoloration was an injury of unknown origin, the facility must know how it happened and should be reported to the California Department of Public Health (CDPH). During an interview on 1/28/2026 at 4:03 p.m., with the Admin, the Admin stated he was not aware of the unexplained bruising of Resident 1. The Admin stated an injury of unknown origin is when the facility is not sure how the injury happened. The Admin stated, we determined how it happened by doing an investigation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and asking the resident. The Admin stated if it was brought to his attention, staff would have investigated and assess the bruising to determine where it came from to rule out abuse. If it came out as an alleged abuse, the facility would report it to CDPH. The Admin stated if we conclude it's not abuse, it's not reportable to CDPH. During a review of facility's policy and procedure (P&P) titled, Abuse Prevention and Management, dated 6/12/2024, the P&P defined Injury of Unknown Source as, an injury that meets both of the following conditions: the source of the injury was not observed by any person and the injury is suspicious because of the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma). The P&P indicated when the Administrator or designated representative received a report of an allegation of an injury of an unknown source, the Administrator or designated representative, should initiate an investigation immediately.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care and services to one of five residents (Resident 1), were provided in accordance with professional standards of practice, by failing to: 1). Ensure Resident 1's left dorsal hand (back of hand) redness was monitored according to the physician ‘s (MD) order. 2). Ensure a follow-up call was made to the MD regarding Resident 1's change of condition (COC) on 1/20/2026. 3). Ensure Treatment Licensed Vocational Nurse's (LVN) did not change left dorsal hand assessment done on 1/2/2026. These failures had the potential to affect the care and services provided to Resident 1 and the potential to delay care, resulting in complications and hospitalization. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 1's diagnoses included Chronic Obstructive Pulmonary Disease ([COPD], a chronic lung disease causing difficulty in breathing) and generalized (affecting throughout the body) muscle weakness. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated 12/19/2025, the MDS indicated Resident 1 had moderate (not extreme) cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 was dependent (helper does all the effort) with Activities of Daily Living (ADLs) such as toileting and personal hygiene. The MDS indicated Resident 1 was dependent with staff in rolling from a lying on back position to her left and right side, from sitting to lying position, lying to sitting on side of bed and sitting to standing position. 1). During a review of Resident 1's COC, dated 1/2/2026 at 9:56 a.m., the COC indicated Resident 1 had redness on her left dorsal hand during treatment. The COC indicated Resident 1 stated the blood pressure was too tight on her wrist. The COC indicated Resident 1's MD recommended to monitor resident's skin for any changes (hematoma, skin breakdown). During a review of Resident 1's Order Summary Report (a list of all current MD's orders) dated 1/2/2026, the Order Summary report indicated to monitor left dorsal hand discolorations (changes in the natural skin tone) for hematoma (a collection of blood outside of blood vessels, typically resulting from an injury or trauma that causes blood to leak into surrounding tissues) formation, skin breakdown, pain/discomfort. Document Y if observed and notify MD. Document N if not observed everyday shift for 30 days. During a review of Resident 1's Treatment Administration Record (TAR), for the month of 1/2026, Resident 1's TAR did not indicate a documented Y if observed or N if not observed, as indicated in the MD's order. During a review of Resident 1's progress notes for the month of 1/2026, Resident 1's progress notes did not indicate that Resident 1's left dorsal hand was monitored as per MD orders. 2). During a review of Resident 1's COC dated 1/20/2026 at 10:25 p.m., the COC indicated Resident 1 had self-inflicted laceration (a deep cut or torn wound in the skin) to bilateral (both) lower legs. The COC indicated staff was awaiting MD's response. During a review of Resident 1's progress notes from 1/20/2026, the progress notes did not indicate staff followed up with Resident 1's MD for orders to treat both lower leg wounds. 3). During a concurrent interview and record review on 1/23/2026 at 2:59 p.m., with the Treatment LVN, Resident 1's Skin Checks, dated 1/4/2026, 1/9/2026, 1/16/2026 and skin check notes dated 1/23/2026, were reviewed. The Treatment LVN stated Resident 1's skin checks on all the dates did not indicate status or description of the left dorsal hand redness. The Treatment LVN could not provide explanation why the skin statuses were not documented. The Treatment Nurse stated she changed her skin check notes on 1/23/2026 to ecchymosis (a type of bruise caused by blood leaking from broken blood vessels into the skin, resulting in a flat, discolored patch) to reflect the Wound MD's left dorsal hand assessment of ecchymosis on 1/23/2026 (wound MD notes not provided). The Treatment LVN stated the assessment (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	became inaccurate because it (ecchymosis) was not her original assessment. During an interview on 1/27/2026 at 1:00 p.m., with LVN 1, LVN 1 stated if staff were unable to get hold of the MD during a resident's COC, staff should attempt to reach out to the MD's nurse practitioner (NP) or could contact the facility's Medical Director to obtain orders. LVN 1 stated if still unsuccessful in obtaining orders during their shift, the staff should endorse to the oncoming shift to ensure residents' safety and care are being taken care of. During an interview on 1/27/2026 at 2:04 p.m., with LVN 2, LVN 2 stated Resident 1's progress notes should indicate the care provided to the residents, including follow-up assessments, monitoring or documentations. During a concurrent interview and record review on 1/27/2026 at 3:55 p.m., with the Director of Nursing (DON) the following were reviewed:Resident 1's TAR, for the month of 1/2026Resident 1's progress notes for the month of 1/2026Resident 1's COC, dated 1/20/2026. The DON stated Resident 1's TAR for the month of 1/2026 did not indicate Y or N indicating Resident 1's left dorsal hand discolorations were observed as indicated in the MD's order. The DON stated Resident 1's progress notes did not indicate staff had followed up with the MD after Resident 1's COC on 1/20/2026. The DON stated if the MD did not respond after Resident 1's COC on 1/20/2026, staff should ensure a follow-up call was made to the MD. The DON stated not following up with the MD could possibly delay Resident 1's care. The DON stated regarding assessments, staff should not change original skin assessment to be accurate. The DON stated a clarification (follow-up documentation) can be documented after MD had assessed something different (changes in the skin). During a concurrent interview and record review on 1/28/2026 at 1:32 p.m., with the Treatment LVN, Resident 1's Skin Check created on 1/27/2026, with an effective date of 1/2/2026 was reviewed. The Treatment LVN stated on 1/2/2026's skin assessment, there was redness on Resident 1's left dorsal hand which was not documented on the skin check form. The Treatment LVN stated she created another skin check form on 1/27/2026 to reflect the redness assessed on 1/2/2026. The Treatment LVN stated charting 25 days after an assessment was performed placed the assessment was inaccurate. During an interview on 1/28/2026 at 3:12 p.m. with the DON, the DON stated staff should date the skin assessment on the day the assessment was performed to ensure accurate information. During a review of facility's policy and procedures (P&P) titled, Completion and Correction, dated 1/1/2012, the P&P indicated entries should be written in chronological sequence and recorded promptly as the events or observations occur. The P&P indicated documentation content should include, treatments, observations during treatments and effectiveness of treatments. During a review of facility's P&P titled, Skin Integrity Management, dated 6/27/2024, the P&P indicated, a Licensed Nurse should complete the skin evaluation weekly. The P&P indicated, treatments administered should be documented in the resident medical record and the Licensed Nurses should document the effectiveness of current treatment for skin integrity problems in the resident's medical record on a weekly basis. During a review of facility's policy and procedure (P&P) titled, Change in Condition, dated 8/25/2022, the P&P indicated, Licensed Nurse should notify the resident's MD when there is an incident/accident involving the resident. The P&P indicated documentation should include the time the MD was contacted, the method by which he was contacted, the response time, and whether or not orders were received.