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	03/02/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three residents (Resident 1), received the necessary services, consistent with professional standards of practice to promote wound healing. The facility failed to:Create a resident-centered plan of care with interventions to manage Resident 1's sacral (lower back) pressure injury (damage to the skin and underlying tissues caused by prolonged pressure, often over bony areas, which can range from mild redness to deep tissue necrosis) when admitted to the facility on [DATE].Update Resident 1's care plan, titled at risk for potential impairment to skin integrity., with interventions to prevent the wound from worsening and promote healing.Implement its policy and procedure (P&P), titled Skin Integrity Management, dated 7/31/2024, which indicated a plan of care should be developed to provide guidelines for the treatment of skin integrity conditions to facilitate healing and update as necessary. This failure resulted in the Resident 1's worsening sacral wound condition and placed the resident at risk for wound infections and other complications, including hospitalizations. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included muscle weakness, Stage III pressure ulcer (Full-thickness loss of skin. Dead and black tissue may be visible) of the sacral region, anemia (a condition where the body does not have enough healthy red blood cells), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). The admission Record indicated Resident 1 had a responsible party (RP 1). During a review of Resident 1's History and Physical (H&P), dated 11/7/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions.During a review of Resident 1's care plan titled Resident 1 is at risk for potential impairment to skin integrity related to long term anticoagulant use (blood thinners), poor bed mobility and advance age, initiated on 11/17/2025 (revised 1/26/2026), the care plan indicated interventions to educate resident/ family caregiver Of causative factors and measures to prevent skin injury, encourage good nutrition and hydration, follow facility protocols for treatment of injury, keep skin clean and dry. During a review of Resident 1's Braden Scale for Predicting Pressure Ulcer Risk Evaluation, dated 12/14/2025, the evaluation indicated Resident 1's occasionally moist skin, chairfast (ability to walk severely limited or non-existent) activity level, and very limited mobility increased his risk for pressure ulcers. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 1 was dependent on staff with toileting hygiene, showering/ bathing self. Resident 1 required substantial/ maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with the ability to roll from lying on back to left and right side and returning to lying on back position, sit to lying, lying to sitting on side of the bed chair/bed-to-chair transfer and toilet transfer. During a review of Resident 1's Interfacility Transfer Report from General Acute Care Hospital (GACH 2), dated 1/5/2026, the Transfer Report indicated to cleanser Resident 1's Stage III pressure injury on the sacral with vashe (a wound solution), pat dry, apply therahoney (a medical grade honey used for wound care) to wound, cover with optifoam (a type of wound dressing) daily and as needed. During a review of Resident 1's facility Clinical Admission, document dated 1/5/2026 at 9:44 p.m., the Clinical (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Admission document indicated Resident 1 arrived and was admitted to the facility. Resident 1 had a wound on the sacrum with redness. The assessment did not indicate description (appearance, size/measurement) of the sacral. The section Documented Pressure Ulcer was blank. During a review of Resident 1's Skin & Wound Evaluation, document dated 1/6/2026, the document indicated a medical device related pressure injury in the sacrum, measuring 2 (unit of measurement- unspecified) in length on admission [DATE]); width 1,5; depth 0,1; wound bed epithelial (tissue); purple discoloration; edges attached and blanched surrounding tissue. The primary dressing indicated xeroform (type of wound dressing). During a review of Resident 1's sacral wound care plan after readmission on [DATE], Resident 1 had no care plan with interventions to address the sacral pressure injury. During a review of Resident 1's Physician Orders, dated 1/6/2026, the order indicated to cleanse sacral pressure injury with normal saline (cleansing solution), pat dry, apply Santyl (skin medication), and cover. During a review of Resident 1's skin checks dated 1/11/2026, the sacral pressure ulcer/ injury was unstageable (a full-thickness pressure ulcer whose depth and severity cannot be determined because the wound bed [base of wound] is obscured [covered] by dead tissue, slough, or eschar), measuring 4 centimeters (cm- a unit of measurement) in length and 4.5 cm in width. During a review of Resident 1's Wound Medical Doctor (MD 1) Wound Assessment and Plan, indicate the following wound assessments:1). On 1/9/2026- Resident 1's coccyx (lower back) pressure DTPI (deep tissue pressure injury, onset date 1/5/20256) was intact, measuring 2.2 cm in length and 1.8 cm in width.2). On 1/16/2026, Resident 1's coccyx pressure injury was unstageable, measuring4 cm in length and 4.5 cm in width with depth that could not be determined. The wound bed tissues had 40% epithelial tissues (the regenerated outer layer of skin tissues appearing as thin, pale pink, or translucent tissue, that covers granulating tissues) and 60% slough (dead tissues) with minimal exudate (drainage). The assessment indicated the wound bed exhibited violaceous (violet-colored) skin, manifesting (displaying) risk for decline to nonviable (dead, damaged, or infected tissue lacking blood supply) tissue. The wound MD wrote an order for x-ray of the sacrococcyx to evaluate for evidence of osteomyelitis (infection and inflammation of the bone). During a concurrent interview and record review on 2/12/2026 at 12:20 p.m., with the Treatment Nurse (TN 1), Resident 1's Clinical admission Assessment, dated 1/5/2026, Care Plans for the month of 1/2026, and Resident 1's Care Plan titled Resident 1 at risk for potential impairment to skin integrity, dated 11/17/2025, were reviewed. The TN 1 stated the admission Assessment indicated that Resident 1 had red wound on his sacrum. Resident 1's care plans did not address his sacral wound. Resident 1's turning program and treatments should have been documented in his care plan to prevent new wounds and further breakdown of his existing wound. During a concurrent interview and record review on 2/12/2026 at 3:00 p.m., with the Registered Nurse (RN 1), Resident 1's care plans for the month of 1/2026, was reviewed. RN 1 stated the licensed nurses should have created a Resident 1-specific care plan when admitted to the facility on [DATE], for the management of his sacral pressure injury. The licensed nurses did not update Resident 1's care plan interventions when the sacral pressure injury had increased in size and when the physician's orders were changed on 1/11/2026 and 1/16/2026. During a concurrent interview and record review on 3/3/2026 at 1:08 p.m., with wound MD 1, Resident 1's Clinical admission Assessment, dated 1/5/2026, Resident 1's Skin Check, dated 1/11/2026, Resident 1's Wound Assessment and Plan, dated 1/16/2026, and Resident 1's Physician Orders, dated 1/16/2026, were reviewed. MD 1 stated Resident 1's risk factors of incontinence, muscle weakness, and cognitive limitations placed him at high risk of pressure ulcer development and worsening. MD 1 stated Resident 1's sacral wound was not assessed and measured by nursing staff upon admission to the facility on 1/5/2026. MD 1 stated Resident 1's pressure injury required RD assessment and recommendations, a plan of care created by nursing and interdisciplinary collaboration to heal. MD 1 stated the missing RD recommendations and lack of care plan likely caused Resident 1's wound to double in size from 1/11/2026 through 1/16/2026. During an interview on 3/3/2026 at 9:28 a.m. with the Registered Dietitian (RD 1), RD 1 stated there was no indication that the RD or dietary department (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addressed Resident 1's pressure injury after it was identified on 1/5/2026. RD 1 stated on 1/5/2026, the RD should have addressed Resident 1's pressure injury, documented her assessment and recommendations, and considered zinc, protein, and hydration supplements to heal Resident 1's pressure injury. RD 1 stated the RD should have reassessed Resident 1's nutritional needs each time his wound worsened. RD 1 stated the care plan intervention to encourage good nutrition was not provided because the RD did not assess or make recommendations to treat Resident 1's sacral pressure injury. During a review of the facility's P&P titled, Skin Integrity Management, dated 7/31/2024, the P&P indicated the facility will identify, evaluate, and intervene to prevent further pressure injury and/or health pressure ulcer. A plan of care will be developed to provide guidelines for the treatment of skin integrity conditions to facilitate healing. A licensed nurse will complete a skin evaluation when there is change in skin integrity and complete the skin evaluation weekly. The P&P indicated the dietary needs of the resident will be evaluated be the RD upon any significant change in skin condition. The licensed nurses will document the effectiveness of the current treatment for skin integrity problems in the resident's medical record on a weekly basis. The IDT will discuss and document recommendations for the skin integrity issues. The residents' care plan will be updated as necessary. During a review of the facility's P&P titled Comprehensive Person-Centered Care Planning, dated 5/22/2025, the P&P indicated the facility must develop and implement a comprehensive person-centered care plan for each resident with measurable objectives and timeframes to meet a resident's physical needs. The care plan must describe the services that are to be furnished, and interventions designed to meet an objective. The care plan will be prepared by an IDT that includes the attending physician, an RN, a nurse aide, a member of the food and nutrition services staff, and other appropriate staff and disciplines as determines by the resident's needs. The resident and the resident representative must attend to the extent practicable, and an explanation for their absence must be documented if it is not practicable for them to attend. During a review of the facility's undated Job Description titled Treatment Nurse, the job description indicated the TN will assess resident's skin condition by doing a complete body assessment on admission and re-admission. The TN will initiate the Nurse's Skin and Wound Progress report upon identification of any skin problem and pressure injury. The TN will notify the dietary consultant promptly about any need for dietary intervention.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a license staff had the specific competencies and skills set necessary to care for one of three resident's (Resident 1) who was readmitted with wound.This failure had the potential to deliver poor quality nursing care and services and placed Resident 1 and other residents with wounds at risk for poor healing and contribute to its worsening wound conditions.Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included muscle weakness, Stage III pressure ulcer (Full-thickness loss of skin. Dead and black tissue may be visible) of the sacral region, anemia (a condition where the body does not have enough healthy red blood cells), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). The admission Record indicated Resident 1 had a responsible party (RP 1). During a review of Resident 1's History and Physical (H&P), dated 11/7/2025, the H&P indicated Resident 1 had fluctuating capacity to understand and make decisions. During a review of Resident 1's care plan titled Resident 1 is at risk for potential impairment to skin integrity related to long term anticoagulant use (blood thinners), poor bed mobility and advance age, initiated on 11/17/2025 (revised 1/26/2026), the care plan indicated interventions to educate resident/ family caregiver of causative factors and measures to prevent skin injury, encourage good nutrition and hydration, follow facility protocols for treatment of injury, keep skin clean and dry. During a review of Resident 1's Braden Scale for Predicting Pressure Ulcer Risk Evaluation, dated 12/14/2025, the evaluation indicated Resident 1's occasionally moist skin, chairfast (ability to walk severely limited or non-existent) activity level, and very limited mobility increased his risk for pressure ulcers. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 1 was dependent on staff with toileting hygiene, showering/ bathing self. Resident 1 required substantial/ maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with the ability to roll from lying on back to left and right side and returning to lying on back position, sit to lying, lying to sitting on side of the bed chair/bed-to-chair transfer and toilet transfer. During a review of Resident 1's Interfacility Transfer Report from General Acute Care Hospital (GACH 2), dated 1/5/2026, the Transfer Report indicated to cleanser Resident 1's Stage III pressure injury on the sacral with vashe (a wound solution), pat dry, apply therahoney (a medical grade honey used for wound care) to wound, cover with optifoam (a type of wound dressing) daily and as needed. During a review of Resident 1's facility Clinical Admission, document dated 1/5/2026 at 9:44 p.m., the Clinical Admission document indicated Resident 1 arrived and was admitted to the facility. Resident 1 had a wound on the sacrum with redness. The assessment did not indicate description (appearance, size/measurement) of the sacral. The section Documented Pressure Ulcer was blank. During a review of Resident 1's Skin & Wound Evaluation, document dated 1/6/2026, the document indicated a medical device related pressure injury in the sacrum, measuring 2 (unit of measurement- unspecified) in length on admission [DATE]); width 1,5; depth 0,1; wound bed epithelial (tissue); purple discoloration; edges attached and blanched surrounding tissue. The primary dressing indicated xeroform (type of wound dressing). During a review of Resident 1's sacral wound care plan after readmission on [DATE], Resident 1 had no care plan with interventions to address the sacral pressure injury. During a review of Resident 1's Physician Orders, dated 1/6/2026, the order indicated to cleanse sacral pressure injury with normal saline (cleansing solution), pat dry, apply Santyl (skin medication), and cover. During a review of Resident 1's skin checks dated 1/11/2026, the sacral pressure ulcer/ injury was unstageable (a full-thickness pressure ulcer whose depth and severity cannot be determined because the wound bed [base of wound] is obscured [covered] by dead tissue, slough, or eschar), measuring 4 centimeters (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(cm- a unit of measurement) in length and 4.5 cm in width. During a review of Resident 1's Wound Medical Doctor (MD 1) Wound Assessment and Plan, indicate the following wound assessments:1). On 1/9/2026- Resident 1's coccyx (lower back) pressure DTPI (deep tissue pressure injury, onset date 1/5/20256) was intact, measuring 2.2 cm in length and 1.8 cm in width.2). On 1/16/2026, Resident 1's coccyx pressure injury was unstageable, measuring4 cm in length and 4.5 cm in width with depth that could not be determined. The wound bed tissues had 40% epithelial tissues (the regenerated outer layer of skin tissues appearing as thin, pale pink, or translucent tissue, that covers granulating tissues) and 60% slough (dead tissues) with minimal exudate (drainage). The assessment indicated the wound bed exhibited violaceous (violet-colored) skin, manifesting (displaying) risk for decline to nonviable (dead, damaged, or infected tissue lacking blood supply) tissue. The wound MD wrote an order for x-ray of the sacrococcyx to evaluate for evidence of osteomyelitis (infection and inflammation of the bone). During an interview on 2/11/2026 at 2:14 p.m., with the Treatment Nurse (TN 1), the TN 1 stated all licensed nurses are responsible for initiating and implementing resident-centered care plans when wounds are identified. The TN 1 stated Resident 1 had no care plan with interventions for his sacral pressure injury on 1/5/2026. She did not know what violaceous indicated in the wound MD's documentation and could not describe the wound based on the Wound Assessment and Plan. The TN 1 stated violaceous (violet-colored) meant that the skin was reddened. If she did not understand the previous wound assessment, she would not be able to know if the wound was improving or worsening. During a concurrent interview and record review on 3/2/2026 at 1:13 p.m., with TN 1, Resident 1's TAR, for the month of 1/2026, TN 1's Time Card Report, dated 1/1/2026 to 1/15/2026, were reviewed. The TN 1 stated she was off on 1/7/2026 and mistakenly signed Resident 1's TAR indicating a treatment was provided to Resident 1's sacral pressure injury. She did not provide treatment on 1/7/2026 and did not photograph Resident 1's sacral pressure injury at any time during the resident's stay at the facility. She was never trained or provided equipment to photograph Resident 1's pressure injury. During a concurrent interview and record review on 3/3/2026 at 1:08 p.m., with MD 1, Resident 1's Clinical admission Assessment, dated 1/5/2026, Resident 1's Wound Assessment and Plan, dated 1/16/2026, were reviewed. MD 1 stated he had issues with the facility's TN's assessment quality. MD 1 stated the TN 1 could not differentiate between Resident 1's violaceous skin and skin redness. MD 1 stated violaceous skin was unhealthy, nearly necrotic, and required intensive interventions, while reddened skin was less urgent and indicated increased blood perfusion. TN 1 should be in-serviced to improve the quality of their assessment. During an interview on 3/12/2026 at 11:20 a.m., with the Medical Records Director (MRD), the MRD stated Resident 1 did not have photographs of his sacral pressure injury in his medical record. During a review of the facility's P&P titled Medical Records Manual - General Completion and Correction, dated 1/1/2012, the P&P indicated medical records will be correct to provide the highest quality and accuracy in documentation. The P&P indicated treatment administration should be accurately documented. The P&P indicated no event should be documented before it occurred. During a review of the facility's undated Job Description titled, Treatment Nurse, the job description indicated the TN should photograph all newly admitted residents with any skin problems and with Stage 2, 3, and 4 pressure ulcers. The job description indicated the TN will notify the dietary consultant promptly about any need for dietary intervention.