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	04/07/2026

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 allegation of abuse to the California Department of Public Health (CDPH) for one of four sampled residents (Resident 3), when Resident 3 reported that Resident 4 hit her on the forehead on 3/30/2026 and Resident 3 sustained a purplish discoloration. This deficient practice resulted in a delay in investigation by the CDPH and placed Resident 3 at risk for continued abuse.Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 3's diagnoses included muscle weakness and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's History and Physical (H&P) dated 12/13/2025, the H&P indicated Resident 3 could make needs known but could not make medical decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 3/21/2026, the MDS indicated Resident 3 was usually able to understand and was understood by others. The MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for Activities of Daily Living (ADLs) such as eating, bed mobility (the ability to roll from lying on back to left and right side, and return to lying back on the bed), sitting to standing and transfers. During a review of Resident 3's Situation, Background, Assessment, Recommendation Summary (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 3/30/2026 at 3:28 p.m., the SBAR indicated Resident 3 was noted with a raised, purplish marking to the mid-forehead area. During a review of Resident 3's Interdisciplinary Care Team (IDT-a group of healthcare professionals from different disciplines who work together to manage the resident's care) Note dated 3/31/2026, the IDT Note indicated on 3/30/2026 at approximately 3:00 p.m., Resident 3 stated she was pushed in the head by another resident (Resident 4) and Resident 3 was noted with raised, purplish marking to mid-forehead. The Note indicated given the absence or suspicion for abuse or a reportable allegation, the incident did not meet criteria for reporting to the CDPH. During a concurrent observation and interview on 4/6/2026 at 12:34 p.m., with Resident 3, Resident 3 was observed with a green and yellowish discoloration extending from the top of the hairline to the bridge of nose and from the right upper margin of eye socket to the left eye upper margin of eye socket. Resident 3 stated she was hit on her forehead by Resident 4. Resident 3 stated she did not know why Resident 4 hit her. Resident 3 stated that she informed staff about the incident but could not remember who. During a review of Resident 4's admission Record, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including muscle weakness and dementia. During a review of Resident 4's SBAR dated 3/30/2026 at 3:53 p.m., the SBAR indicated on 3/30/2026 at approximately 3:00 p.m., Resident 4 had a resident-to-resident contact, and the Physician recommended the resident for psychology/psychiatric consult. During a review of Resident 4's IDT Note dated 3/31/2026 at 1:25 p.m., the IDT Note indicated on 3/30/2026 at approximately 3:00 p.m., Resident 4's roommate (Resident 3) alleged that Resident 4 made contact with Resident 3 and pushed the resident (Resident (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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(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	3) in the head. The IDT note indicated Resident 4 did not have visible injuries and the resident was unable to provide additional information due to cognitive (ability to think and reason) impairment. During an interview on 4/6/2026 at 1:44 p.m., with LVN 1, LVN 1 stated Resident 3 alleged Resident 4 hit her on the forehead. LVN 1 stated the facility should have reported the incident to the CDPH, ombudsman, and police no later than two hours so the incident could be investigated immediately and keep residents safe. During interviews on 4/6/2026 at 3:54 p.m. and 4/9/2026 at 12:53 p.m., with the Director of Nursing (DON), the DON stated CNA 5 reported to her that Resident 3 alleged Resident 4 hit her on the head. The DON stated the facility did not report the incident (abuse allegation) between Resident 3 and Resident 4 to the CDPH because according to the SOC 341(Report of Suspected Dependent Adult/Elder Abuse - a standard form in California used by mandated reporters to document and report suspected abuse, neglect, or exploitation of an elder [age 65+] or a dependent adult [age 18-64 with limitations]), abuse involving residents with dementia did not have to be reported. The DON stated the facility also did not report the incident because after investigating, the facility determined that no abuse occurred between the residents. During an interview on 4/9/2026 at 10:42 a.m., with CNA 5, CNA 5 stated Resident 3 reported to her that Resident 4 hit her on the forehead with her fist. CNA 5 stated, she could not recall the date of the incident but had immediately reported the allegation to the LVN and DON. During a review of the facility's Policy and Procedure (P&P) titled, Abuse Prevention and Management dated 5/30/2024, the P&P indicated for all allegations of abuse, the Administrator or designated representative will notify law enforcement, by telephone immediately, or as soon as practicably possible, but no longer than (2) hours of an initial report and send a written SOC341 report to the Ombudsman, Law Enforcement, and CDPH Licensing and Certification within (2) hours.