

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER LA Brea Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 505 N. LA Brea Avenue Los Angeles, CA 90036	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>44309</p> <p>Based on interview and record review, the facility failed to develop a complete baseline care plan for one of five sampled residents (Resident 3) within 48 hours of resident's admission.</p> <p>This deficient practice had the potential for delayed administration of necessary care and services.</p> <p>Findings:</p> <p>A review of Resident 3's Admission Record (Face Sheet) indicated the facility admitted the resident on 7/18/2024, with diagnoses including encephalopathy (a change in your brain function due to injury or disease) and type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>A review of Resident 3's Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 7/25/2024, indicated the resident's cognitive skills for daily decision making (ability to think, remember, and make decisions) was severely impaired (never/rarely made decisions). The MDS indicated Resident 3 required partial/moderate assistance for oral hygiene, toileting hygiene, upper and lower body dressing, showering/bathing, and personal hygiene.</p> <p>During a concurrent interview and record review on 9/12/2024 at 8:15 AM with Licensed Vocational Nurse (LVN) 1, Resident 3's baseline care plan was reviewed. LVN 1 stated staff initiated Resident 3's base line care plan on 7/19/2024. However, there were sections of the base line care plan that were not completed. LVN 1 further stated Resident 3's base line care plan for skin care and bowel/bladder needs, discharge goals, ethical/cultural preferences, nail care, equipment, meal location preference, and special treatments/procedures sections were not completed. LVN 1 stated licensed nurses were required to complete a resident's base line care plan thoroughly within 72 hours of the admission to the facility. LVN 1 stated the potential outcome of not completing the base line care plan thoroughly was the inability to meet Resident 3's immediate care needs.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/2024 at 1:15 PM, the Interim Director of Nursing (IDON) stated a Resident 3's base line care plan was required to be completed within 48 hours of admission to the facility, and that Resident 3's base line care plan was not completed thoroughly as some parts were missing. The IDON further stated the potential outcome of not developing a complete base line care plan upon admission was the inability to meet resident's care needs and the inability to delivery necessary services to the resident.</p> <p>A review of the facility's policy and procedure titled, Care Plans-Baseline, revised February 2024, indicated a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident. The baseline care plan was used until the staff conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan. The baseline care plan was updated as needed to meet the resident's needs until the comprehensive care plan was developed.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309</p> <p>Based on interview and record review, the facility failed to provide the necessary treatment and services for two of five sampled residents (Resident 3 and Resident 5) consistent with the residents' needs and professional standards of practice, by failing to:</p> <ul style="list-style-type: none"> -Ensure Resident 3 received wound treatment for right posterior hip unstageable (full-thickness skin and tissue loss in which actual depth of the ulcer is completely obscured by slough-yellow, tan, green or brown and/or eschar-tan, brown, or black, in the wound bed) pressure injury (localized injury to the skin and or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear-layers are laterally shifted in relation to each other, and or friction-surfaces sliding against each other). -Ensure Resident 5 received wound treatment for coccyx (tailbone) Stage IV pressure injury (full thickness skin loss extended to muscle, tendon, or bone). These deficient practices had the potential for Resident 3 and Resident 5 to have further skin breakdown, to develop a new pressure injury, and possible infection. <p>Findings:</p> <p>a. A review of Resident 3's Admission Record (Face Sheet) indicated the resident was admitted to the facility on [DATE], with diagnoses including encephalopathy (a change in your brain function due to injury or disease), and Type II diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>A review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 7/25/2024, indicated Resident 3's cognitive skills for daily decision making (ability to think, remember and make decisions) was severely impaired (never/rarely made decisions). The MDS indicated Resident 3 required partial/moderate assistance for oral hygiene, toileting hygiene, upper and lower body dressing, showering/bathing, and personal hygiene. The MDS further indicated Resident 3 had one Stage II (skin breaks open, wears away, or forms an ulcer, which is usually tender and painful) pressure injury, two unstageable pressure injuries, and two Stage III (full thickness ulcer that might involve the subcutaneous [under all layers of skin] fat) pressure injuries that were present upon admission.</p> <p>A review of the Physician's Order Summary dated 8/7/2024, indicated to apply santyl external ointment (a topical medication used to remove damaged or burned skin) to right posterior hip topically (used on the outside of the body) every day shift for unstageable pressure injury for 21 days. The order further indicated to clean the wound with Normal Saline (NS-sterile salt solution), pat dry, apply Santyl and cover with foam dressing.</p> <p>A review of Resident 3's Treatment Administration Record (TAR) for August 2024, indicated Santyl external ointment was not documented to be administered to Resident 3's right posterior hip pressure injury on 8/21 and 8/23/2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. A review of Resident 5's Admission Record indicated the facility originally admitted the resident on 8/16/2007, and readmitted on [DATE], with diagnoses including Type II diabetes mellitus and Stage IV pressure ulcer of sacral region (the portion of spine between lower back and tailbone).</p> <p>A review of the MDS dated [DATE], indicated Resident 5's cognitive skills for daily decision making (ability to think, remember, and make decisions) was severely impaired (never/rarely made decisions). The MDS indicated Resident 5 was dependent for rolling left and right, oral hygiene, toileting hygiene, upper and lower body dressing, showering/bathing, and personal hygiene. The MDS further indicated Resident 5 had one Stage IV pressure injury that was present upon admission.</p> <p>A review of Resident 5's Care Plan dated 5/28/2024, indicated the resident had a Stage IV pressure ulcer at her coccyx and had the potential for pressure ulcer development related to history of ulcers and immobility. The care plan goal was for the resident to show signs of healing and remain free from infection. The care plan interventions were to administer medications as ordered by the physician. Administer wound treatment as ordered by the physician. Monitor for effectiveness of the treatment, assess/monitor/record wound healing and healing process and to report improvements and declines to the physician.</p> <p>A review of the Physician's Order Summary dated 8/11/2024, indicated to apply Medi honey external paste (gel made from honey for wound management) to both buttocks-coccyx area of Resident 5 topically every day shift, for pressure injury Stage IV for 21 days. Cleanse with Normal Saline (NS-sterile salt solution), pat dry, apply Medi honey and cover with bordered gauze.</p> <p>A review of Resident 5's TAR for August 2024, indicated Medi honey external paste was not documented to be administered to Resident 5's buttocks-coccyx Stage IV pressure injury on 8/23, 8/26, 8/28, and 8/31/2024.</p> <p>During a concurrent interview and record review on 9/12/2024 at 10:52 AM, with the facility's Treatment Nurse (TN), Resident 3 and Resident 5's TARs were reviewed. The TN stated staff did not document that they provided wound treatment for Resident 3's right posterior hip pressure injury on 8/21, and 8/23/2024. The TN stated, if it is not documented, it is not done. The TN stated staff did not document they provided wound treatment to Resident 5's coccyx Stage IV pressure injury on 8/23, 8/26, 8/28, and 8/31/2024. The TN further stated the potential outcome of not performing wound treatment for residents with pressure injuries as per physician order was worsening of the wound and infection.</p> <p>During an interview on 9/12/2024 at 1:26 PM, with the Interim Director of Nursing (IDON), the IDON stated there were missing documentations for wound treatment in Resident 3 and Resident 5's TARs. The IDON stated there were occasions that nurses were performing the wound treatment, but they were forgetting to document it in the resident's medical record. The IDON stated, if the task is not documented then it is considered not done. Seems like Resident 3 did not receive wound care for his pressure injury on 8/21 or 8/23/2024. Resident 5 did not receive wound care for her coccyx Stage IV pressure injury on 8/23, 8/26, 8/28 or 8/31/2024. The IDON stated the potential outcome of not performing wound treatment as per physician order was worsening of the wound and infection.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy and procedure titled, Wound Care, revised February 2024, indicated the purpose of this procedure was to provide guidelines for the care of wounds to promote healing. Verify that there was a physician's order for this procedure. Review the resident's care plan to assess for any special needs of the resident. Record the type of wound care given, the date and time the wound was given, the position in which the resident was placed, the name and title of the individual performing the wound care, the signature and title of the person recording the data.</p> <p>A review of the facility policy and procedure titled, Charting and Documentation, revised February 2024, indicated all services provided to the resident, progress forward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The following information was to be documented in the residents medical records: treatment or services performed. Documentation of procedures and treatments will include care specific details including the date and time the procedure /treatment was provided and the name and title of the individual who provided the care.</p> <p>A review of the facility policy and procedure titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised February 2024, indicated the physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical agents.</p>		