

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 11/06/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50296</p> <p>Based on interview and record review, the facility failed to ensure two of three sampled residents (Resident 1 and Resident 2) were free from physical abuse (deliberately aggressive or violent behavior by one person toward another that results in bodily injury) from Resident 3. Resident 3 slapped Resident 2 in the arm and assaulted Resident 1 in the activity room where facility staff was present and there was no documented monitoring of Resident 3, per the Mood Problem care plan interventions. This deficient practice resulted in Resident 1 sustaining a bloody lip with jaw pain, and was transferred to the General Acute Care Hospital for evaluation.</p> <p>Findings:</p> <p>a.A review of Resident 3's admission record indicated the resident was admitted to the facility on [DATE] with a diagnoses including peripheral vascular disease (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the limbs or other organ), and cellulitis (a bacterial infection that affects the skin and tissues beneath it).</p> <p>A review of Resident 3's Mood Problem related to Admission care plan, dated 8/7/23, indicated Resident 3 had a history of non-compliance and the interventions indicated to monitor / record / report to the physician acute episodes of feeling sad, loss of pleasure and interest in activities.</p> <p>A review of Resident 3's Progress notes indicated there was no monitoring of episodes for feeling sadness, loss of pleasure and interest in activities.</p> <p>A review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 8/13/24, indicated the resident had no issues with feeling down, depressed, or hopeless. The MDS indicated Resident 3 did not present with little interest or pleasure in doing things. This indicated a discrepancy and inaccurate assessment when compared to the Mood Problem care plan date 8/7/23.</p> <p>A review of Resident 3's Situation, Background, Assessment, and Recommendation (SBAR - a framework that can assist in communication quickly and clearly in the healthcare setting), dated 10/30/24, indicated the resident had an altercation with other residents (Resident 1 and Resident 2).</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Social Services note dated 10/30/24, indicated Resident 3 was visited once a day for two days for evaluation after the incident with Resident 1 and Resident 2. The Social Services note, indicated Resident 3 did not want to talk about the incident but Resident 3 stated, All I can say is that I'm sorry. I was just mad. The social service note dated 11/1/24, indicated Resident 3 was discharged to a board and care facility (a lower level of care).</p> <p>b.A review of Resident 1's SBAR dated 10/30/24, indicated the resident had soreness to the right jaw, neck, back, and left knee due to an altercation with Resident 3 on 10/29/24. The SBAR indicated Resident 1's primary physician was notified.</p> <p>A review of Resident 1's Progress notes, dated 11/1/24, indicated the resident was transferred to the General Acute Care Hospital (GACH) for evaluation due to complaints of neck, jaw, and left knee pain. The Progress note indicated the resident returned to the facility on [DATE] with no new orders, the facility continued monitoring Resident 1.</p> <p>A review of Resident 1's psychiatrist consult, dated 11/1/24, indicated Resident 1 was calm, cooperative, and able to verbalize needs. The psychiatrist consult indicated staff to continue to monitor and report any changes.</p> <p>During an interview on 11/6/24 at 11:54 AM, with Resident 1 in his room, Resident 1 stated that Resident 3 was beating on Resident 2 and I got involved. Resident 1 stated he and Resident 3 got into it. Resident 1 stated he sustained an injury to his right cheek, a bloody lip, and right neck and shoulder pain. Resident 1 stated he felt safe at the facility and liked living there. Resident 1 stated he had no prior interaction with Resident 3. Resident 1 stated the psychiatrist conducted a visit.</p> <p>During an interview on 11/6/24 at 11:24 AM, the Administrator (ADM) stated the residents were watching the TV in the activities room. Resident 3 got upset and went into the activities room and hit Resident 2. Resident 2 stated that another resident, Resident 1, was assaulted by Resident 3. The ADM stated supervision was in the room and witnessed by the assistant activities director.</p> <p>c.A review of Resident 2's admission record indicated the resident was admitted to the facility on [DATE], with a diagnoses including hemiplegia (the partial or total loss of movement to one side of the body) following cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked) and altered mental status.</p> <p>A review of Resident 2's MDS, dated [DATE], indicated Resident 2 did not have feelings of depression or hopelessness, or little interest or pleasure in doing things.</p> <p>A review of Resident 2's SBAR, dated 10/30/24, indicated the resident had an altercation with another resident (Resident 3) while watching TV in the activity room. The SBAR indicted the resident's primary physician was notified.</p> <p>A review of Resident 2's Progress note, dated 10/30/24, indicated the resident was involved in an altercation with Resident 3.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/6/24 at 12:04 PM, with Resident 2 in the activities room, Resident 2 stated, everyone was watching tv in the activities room. Resident 2 stated Resident 3 slapped him on the right arm on 10/29/24. Resident 2 stated the assistant activities director was in the room. Resident 2 stated the incident was not an accident and that his doctor came to see him. Resident 2 stated he felt safe at the facility.</p> <p>During an interview on 11/6/24 at 1:06 PM, with the Activities Director (AD) and the Assistant Activities Director (AAD), the AD interpreted for the AAD. The AAD stated at around 7 pm, the residents finished dinner, and were watching TV. Resident 3 was not watching TV but came into the activity room, went to speak to Resident 2, and pushed him in the right side of the chest. The AAD stated Resident 3 then pushed Resident 1 in the chest. Resident 1 fell back into his chair. Resident 1 got up and pushed Resident 3 and the AAD stepped in front of Resident 2 and was telling Resident 1 and Resident 3 to stop. Resident 1 and Resident 3 pushed each other two more times. The AAD asked a staff member from the kitchen to help separate the two residents. The AAD assisted Resident 2, and the other staff told Resident 3 to go wait outside his room. The AAD stated she did not know why Resident 3 was upset and that Resident 1 had a scratch to the right side of his neck, and she saw that Resident 1 had a little blood in his mouth.</p> <p>During an interview on 11/6/24 at 3:40 PM, the Administrator (ADM) and the Director of Nursing (DON) stated upon admission the residents were instructed on resident rights which included freedom from abuse. The ADM stated on the day of the incident he received a text at 8:45 PM, he came to the facility, conducted the investigation, and reported the abuse to the ombudsman, California Department of Public Health, and the Police Department. The ADM stated his investigation concluded the attack was incidental, abuse did occur, but supervision was there.</p> <p>During an interview on 11/6/24, the Abuse Policies were requested from the medical records staff. The medical records staff provided the policy Abuse Investigation and Reporting, and Charting and Documentation but there was no reference to Abuse Prevention.</p> <p>A review of the facility's policy and procedures titled, Resident Rights, dated 2/2024, indicated federal and state laws guarantee basic rights at the facility which include to be free from abuse, neglect, and exploitation. The resident had the right to a dignified existence and have the facility respond to his or her grievances.</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** 50296</p> <p>Based on interview and record review the facility failed to implement the comprehensive care plan interventions for two of three sampled residents (Resident 2 and Resident 3). Both residents were not monitored after an altercation with another resident, per the care plan interventions. This deficient practice had the potential to result in missed opportunity for any changes in the residents.</p> <p>Findings:</p> <p>a.A review of Resident 2's admission record indicated the resident was admitted to the facility on [DATE], with a diagnoses including hemiplegia (the partial or total loss of movement to one side of the body) following cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked) and altered mental status.</p> <p>A review of Resident 2's MDS, dated [DATE], indicated Resident 2 showed no delirium issues and did not have feelings of depression or hopelessness, or little interest or pleasure in doing things.</p> <p>A review of Resident 2's SBAR, dated 10/29/24, indicated Resident 2 had an altercation with another resident while watching TV in the activity room, no injuries sustained. The SBAR indicated Resident 2 did not have a mental, functional status change, respiratory, abdomen or urine changes. The SBAR indicted the resident's primary physician was notified.</p> <p>A review of Resident 2's Alteration in Mood/Behavior Care plan, dated 10/30/24, indicated the goal that the resident must not have an injury for 30 days with a reevaluation date of 1/25. The progress note indicated the resident should be monitored for changes in conduct.</p> <p>A review of Resident 2's Progress note, dated 10/30/24, indicated Resident 2 was involved in an altercation with another resident (Resident 3). No other nurses note indicated in progress notes monitoring of resident's conduct after 10/30/24.</p> <p>A review of Resident 2's psychiatrist consult, dated 11/1/24, indicated Resident 2 was calm and cooperative. The consult note indicated Resident 2 denied any history of mental health issues, feelings of depression, anxiety, or hallucinations. The consult indicated the staff to continue to monitor Resident 2 and report any changes.</p> <p>A review of the physician's visit note, dated 11/1/24, indicated Resident 2 stated he was okay. The physician's visit note indicated Resident 2 appeared comfortable.</p> <p>During an interview on 11/6/24 at 12:04 pm, with Resident 2 in the activities room, Resident 2 stated Resident 3 slapped him on the right arm and the assistant activities director was in the room. Resident 2 stated he did not want to see anyone from psychiatry after the incident. Resident 2 stated the incident was not an accident.</p> <p>(continued on next page)</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>During a concurrent interview and record review on 11/6/2024 at 3:40 pm with the Director of Nursing (DON), Resident 2's Progress notes, dated 10/30/24 was reviewed. The Progress notes indicated the resident was monitored on 10/30/24 at 11:04 pm for altercation with another resident while watching TV in the activity room. No other progress notes noted after the date of 10/30/24 for monitoring the resident. The DON confirmed that Resident 2 was not monitored every shift after the incident. The DON stated the result to the resident without proper monitoring per the care plan would be that there is a missed opportunity for any changes.</p> <p>b.A review of Resident 3's admission record indicated the resident was admitted to the facility on [DATE] with a diagnoses of peripheral vascular disease (a condition that occurs when blood vessels narrow or become blocked, reducing blood flow to the limbs or other organ), and cellulitis (a bacterial infection that affects the skin and tissues beneath it).</p> <p>A review of Resident 3's Mood Problem related to Admission care plan, dated 8/7/23, indicated Resident 3 had a history of non-compliance. The goal indicated Resident 3 would have improved mood stated happier, calmer appearance, no signs or symptoms of depression, anxiety, or sadness through the review date. The goal was revised on 10/8/24.</p> <p>A review of Resident 3's Progress notes indicated no monitoring for episodes of feeling sadness, loss of pleasure and interest in activities.</p> <p>A review of Resident 3's MDS, dated [DATE], indicated Resident 3 had no issues with feeling down, depressed, or hopeless. The MDS indicated Resident 3 did not present with little interest or pleasure in doing things.</p> <p>A review of the Social Services note indicated Resident 3 was visited once a day for two days for evaluation after the incident. A review of Resident 3's Social Services note, dated 10/30/24, indicated Resident 3 did not want to talk about the incident. A review of Resident 3's Social Services note, dated 11/1/24, indicated Resident 3 was discharged to a board and care facility.</p> <p>During concurrent interview and record review on 11/6/24 at 3:40 pm, with the DON, Resident 3's Mood Problem related to Admission, History of Noncompliant Medication Care Plan, dated 8/7/23 were reviewed. The care plan dated, 8/7/23, was revised on 10/8/24. The DON stated it was time for the yearly revision which was 10/8/24. The DON stated the nurses were not monitoring Resident 3 for this care plan due to no psychiatric diagnosis.</p> <p>A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated 6/2024, indicated the care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs, and was developed and implemented for each resident.</p> <p>A review of the facility's policy and procedure titled, Charting and Documentation, dated 2/2024, indicated, all services provided to the resident, progress toward 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.</p>		