STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056195	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Brea Rehabilitation Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility staff failed to ensure physician (MD) notification was done for one of nine sampled residents (Resident 1's) change of condition (COC/CIC) by failing to notify MD when Resident 1 had multiple episodes of refusal of basic care. This deficient practice had the potential to result in possible delayed provision of necessary care and services to Resident 1. Cross Referenced F656 Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including carcinoma (cancer cells) in the rectum (final section/ part of the lower gastrointestinal tract [GI tract-organ system of the body from the mouth to the anus [part of the GI tract where the stool or feces are being eliminated from the body], colostomy (opening of the large intestine [abdominal area] to the outside of the body for passing of stool and gas) and abnormalities of gait (ambulation) and mobility. A review of Resident 1's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 12/6/2024, indicated Resident 1 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and needing moderate assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 1's medical record indicated missing documentation that Resident 1 had multiple episodes of refusals of basic care. During an interview with Certified Nursing Assistant 3 (CNA 3) on 3/25/2025 at 12:59 p.m., CNA 3 stated that Resident 1 had been refusing basic care. CNA 3 also stated that she (CNA3) notified the charge nurse via Stop and Watch (a warning tool that identify any change while caring for a resident). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA 4 on 3/25/2025 at 1:13 p.m., CNA 4 stated that Resident 1 had also been refusing basic care during the night shift. CNA 4 also stated that he (CNA 4) notified the charge nurse. During an interview with the Director of Staff Development (DSD), on 3/25/2025 at 2:52 p.m., DSD stated and validated that Resident 1 had multiple episodes of refusals of care and was made aware by the CNAs. DSD also stated that when a resident refuses any care, the CNAs should notify the charge nurse and charge nurse must report to the MD and document via COC/CIC so they are able to monitor the resident's issue. During an interview with the Quality Assurance Nurse (QAN), on 3/25/2025 at 3:13 p.m., QAN stated and validated missing documentation with Resident 1's refusals of basic care. QAN also stated that a COC/CIC documentation must be done for any refusals of care. A review of the facility's policy and procedures (P&P), titled, Change in Resident's Condition or Status, reviewed on 12/2024, P&P indicated that facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition and/or status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on interview and record review, the facility staff failed to develop and implement a comprehensive care plan that meet the care/services based on the resident ' s individual assessed needs for one of nine sampled residents (Resident 1) by failing to ensure Resident 1 ' s episodes of refusal of basic care were care planned. This deficient practice had the potential to result negative impact on Resident 1 ' s health and safety, as well as the quality of care and services received. Cross Referenced F580. Findings: A review of Resident 1 ' s Admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and was readmitted on [DATE] with diagnoses including carcinoma (cancer cells) in the rectum (final section/ part of the lower gastrointestinal tract [GI tract-organ system of the body from the mouth to the anus [part of the GI tract where the stool or feces are being eliminated from the body], colostomy (opening of the large intestine [abdominal area] to the outside of the body for passing of stool and gas) and abnormalities of gait (ambulation) and mobility. A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/6/2024, indicated Resident 1 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and needing moderate assistance from staff for activities of daily living (ADL-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). A review of Resident 1 ' s medical record indicated missing care plan that Resident 1 had multiple episodes of refusals of basic care. During an interview with Certified Nursing Assistant 3 (CNA 3), on 3/25/2025 at 12:59 p.m., CNA3 stated that Resident 1 had been refusing basic care. CNA 3 also stated that she (CNA 3) notified the charge nurse via Stop and Watch (a warning tool that identify any change while caring for a resident). During an interview with CNA 4 on 3/25/2025 at 1:13 p.m., CNA 4 stated that Resident 1 had also been refusing basic care during the night shift. CNA4 also stated that he (CNA 4) notified the charge nurse. During an interview with the Director of Staff Development (DSD), on 3/25/2025 at 2:52 p.m., DSD stated and validated that Resident 1 had multiple episodes of refusals of care. DSD also stated that when a resident refuses any care, the CNAs should notify the charge nurse and charge nurse must report to the MD and document via COC/CIC and start a care plan so they are able to monitor the resident ' s issue and plan a solution to assist the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Quality Assurance Nurse (QAN), on 3/25/2025 at 3:13 p.m., QAN stated and validated missing care plan with Resident 1 ' s refusals of basic care. QAN also stated that a care plan must be initiated for any refusals of care. A review of the facility ' s policy and procedures (P&P), titled, Care Plans, Comprehensive Person-Centered reviewed on 12/2024, the P&P indicated that interdisciplinary team reviews and updates the care plan when there has been a change in resident ' s condition and refusals are documented in the resident ' s clinical record in accordance with established policies.

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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 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** 43261 Based on observation, interview and record review, the facility failed to provide the necessary treatment and service to one of three sampled residents (Resident 4) consistent with the resident's needs and professional standard of care by failing to ensure low air loss (LAL) mattress was set up properly for Resident 4. This deficient practice can place Resident 4 at risk of poor wound healing of the current pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) and possibly development of a new pressure injury. Findings: A review of Resident 4's Admission Record indicated Resident 4, was admitted to the facility on [DATE] with diagnoses including paraplegia (paralysis of the legs and lower body), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and osteomyelitis (bone infection). A review of Resident 4's Minimum Data Set (MDS-a resident assessment tool), dated 10/21/2024, indicated Resident 4 was moderately impaired in cognitive skill (thought processes) for daily decision making and needing one to two-person assistance with staff on activities of daily living (ADLs-bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene). Resident 4's MDS indicated Resident 4 has currently has pressure ulcer, high risk for developing pressure ulcers with treatment to provide pressure reducing device for bed. A review of Resident 4's Order Summary Report (OSR), dated 11/13/2024, OSR indicated a physician (MD) order LAL therapy bed for treatment and management of pressure ulcer and monitor every shift. A review of Resident 4's monthly weight report, indicated Resident 4 weighed at 149 pounds (lbs.) in March 2024. During a concurrent observation and interview with the Treatment Nurse 1 (TX1) on 3/25/2025 at 10:31 a.m., observed Resident 4's LAL mattress was currently set at weight 200 lbs. TX1 stated and validated that Resident 4's LAL mattress was supposed to be set according to Resident 4's current weight, not at 200 lbs. During an interview with the Director of Staff Development (DSD) on 3/25/2025 at 2:52 p.m., DSD stated that LAL mattress should be set based on resident's weight. A review of the facility's policy and procedures (P&P), titled, Support Surface Guidelines reviewed on 12/2024, P&P indicated that Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43261 Based on observation, interview and record review, the facility failed to timely document administered medications per facility policy to three of four sampled residents (Residents 6, 7 and 8). This deficient practice had the potential to result in unsafe, and improper medication administration per facility policy. Findings: a. A review of Resident 6's Admission Record indicated Resident 6 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid), congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should) and gastrostomy (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration). A review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/2025, indicated Resident 6's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision-making was severely impaired and dependent from staff for activities of daily living (ADLs- bed mobility, transfer, dressing, and toilet use). A review of Resident 6's Medication Administration Record (MAR), dated 3/25/2025 at 12:32 p.m., indicated an unsigned scheduled administration medication at 9:00 a.m. for the following medications: Amlodipine Besylate (antihypertensive medication) 5 milligram (mg, unit of measurement) one tablet via GT one time a day (QD) Lasix (medication to treat fluid retention) 20 mg via GT QD Losartan Potassium (antihypertensive medication) 100 mg; give half a tablet via GT QD Ocusoft Lid Scrub (eye cleanser medication) apply to eyes QD Ferrous Sulfate (iron medication) liquid give 7.5 millimeter (ml) via GT two times a day Keppra (anti-seizure medication) 5 ml via GT two times a day Artificial Tears ophthalmic (eye lubricant) solution instill one drop to both eyes three times a day b. A review of Resident 7's Admission Record indicated Resident 7 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), lack of coordination and gastrointestinal (GI) bleed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7's MDS, dated [DATE], indicated Resident 7's cognitive skills for daily decision-making was severely impaired and dependent from staff for ADLs. A review of Resident 7's MAR, dated 3/25/2025 at 12:32 p.m., indicated an unsigned scheduled administration medication at 9 a.m. for the following medications: Amlodipine Besylate 5 mg one tablet via mouth (PO) QD Citalopram (anti-depression medication) 20 mg PO QD Ferrous Sulfate tablet give 325 mg PO QD Losartan Potassium 50 mg PO QD Multivitamin (MVI) 1 tablet PO QD Eliquis (medication to prevent blood clots) 5 mg PO twice a day Mesalamine (anti-inflammatory medication) 400 mg, give two capsule three times a day c. A review of Resident 8's Admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including multiple sclerosis (MS- a disabling disease of the brain and spinal cord [central nervous system]), COVID-19 (Coronavirus- a deadly respiratory disease transmitted from person to person) and lack of coordination. A review of Resident 8's MDS, dated [DATE], indicated Resident 8's cognitive skills for daily decision-making was severely impaired and needing maximal assistance from staff for ADLs. A review of Resident 8's MAR, dated 3/25/2025 at 12:32 p.m., indicated an unsigned scheduled administration medication at 9:00 a.m. for the following medications: Haldol (medication to treat mental disorders) 5 mg PO QD. Docusate Sodium (DSS-stool softener) 100 mg PO twice a day Lactobacillus (probiotic medication) one capsule PO twice a day Magnesium (vitamin) 400 mg PO twice a day During a concurrent observation and interview with Registered Nurse 2 (RN 2) on 3/25/2025 at 12:32 p.m., observed RN2 sitting in the nursing station about to sign Resident 6, 7 and 8's MAR for the medications scheduled at 9:00 a.m. RN2 stated and validated that the scheduled 9 a.m. medications were already administered on time and RN2 was barely about to sign the MAR that was administered. RN2 stated that she (RN 2) was supposed to sign the MAR right after administering the medication given to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Quality Assurance Nurse (QAN) on 3/25/2025 at 3:13 p.m., QAN stated that facility staff nurse should sign the MAR right after administering the medication to the resident. QAN also stated that it was unacceptable to administer medication at 9:00 a.m., and then sign MAR at around 12:00 p. m. A review of the facility's policy and procedures (P&P), titled, Documentation of Medication Administration, reviewed on 12/2024, P&P indicated that Administration of medication must be documented immediately after it is given.