

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  09/11/2025
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)
F 0604  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.  (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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure that the residents were free of unnecessary physical and chemical restraints (use of medication to manage a person's behavior or restrict their movement) with a medication Haloperidol (Haldol- is a first-generation or typical antipsychotic medication used to treat psychotic disorders and severe behavioral issues), for one of three sampled residents (Resident 3). This deficient practice resulted in unnecessary restraint and placed the resident at risk of potentially life-threatening results, including physical injury, cognitive decline, psychological trauma, and even death. During a review of the admission record for Resident 3 indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), history of falling, and Hyperlipidemia (HLD- a condition in which there are abnormally high levels of lipids [fats] in the blood) During a review of history and physical (H&amp;P- is a thorough assessment a doctor does to understand a patient's health. It involves asking about the patient's past and current health problems [the history] and then examining the patient's body to look for signs of illness [the physical examination], dated 8/18/2025, indicated Resident 3 Family Member (FM) 1 as the responsible party. During a review of Resident 3 ' s Minimum Data Set (MDS - a resident assessment tool) dated 8/5/2025, indicated Resident 3 had severe cognitive impairment (a person has great difficulty with thinking, learning, remembering, and making decisions, to the point where they can't live independently). The same MDS indicated Resident 3 mostly required substantial/maximal assistance for his Activities of Daily Living such as: (ADLs- routine tasks/activities such as oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of the physician order dated 8/18/2025 indicated, Haloperidol 1 mg (milligram) tablet, take 1 tablet by mouth every 6 hours for psychosis for 14 days (stop 9/1/2025). Hold if sedation/RTC (difficult to arouse and return to clinic for follow up). During a review of Resident 3's care plan (a written, personalized document that details a person's health and personal needs, the goals of care, and how that support will be provided. It serves as a guide and a communication tool for the individual, their family, and healthcare providers to ensure consistent, coordinated, and personalized care that meets the person's specific needs, goals, and preferences) initiated 8/23/2025 indicated a focus of Actual incident of fall: UNWITNESSED FALL, with interventions including:- Apply restraint as ordered- Frequent visual monitoring- Place call light within easy reach During an interview with Resident 4 on 9/5/2025 at 10:34 am, Resident 4 stated that he was concerned for Resident 3 who was his roommate of the numerous falls and fell at least twice a day. Resident 4 stated that facility staff not only restrained Resident 3 with an unknown object but also, drugged him like a zombie, to prevent him (Resident 3) from falling. During an observation of Resident 3 on 9/5/2025 at 10:38 am, Resident 3 was observed lying down in a Geri chair (a large, padded, often wheeled chair designed to help seniors or individuals with limited mobility) at the foot of his bed against the wall and was asleep. Resident 3 did not arouse a call of his name and a gentle shake. Resident was noted to have bruises and scab to both arms and legs During an interview with Family Member (FM) 1 on 9/11/2025 at 1:55 pm, FM 1 stated that facility staff ad called her to get her consent about applying a restraint for Resident 3 because he was too aggressive and striking staff and was attempting to get up and had fallen on multiple occasions. FM 1 stated that she (FM 1) gave the facility consent to apply the restraint and had observed Resident 3 during one of her visits to the facility. FM 1 stated that the restraint was tied around Resident 3 abdomen and secured to his (Resident 3) bed. FM 1 stated that Resident 3 was unable to remove the restraint. During a concurrent observation and interview of Resident 3's medication bubble packs (blister pack/multi-dose pack, is a sealed card that organizes medications by dose, date, and time. Each dose is contained in its own transparent, plastic bubble or compartment, which is sealed with a foil or paper backing) with the Director of Nursing (DON) on 9/11/2025 at 3:35 pm, the DON confirmed that there were two bubble packs one marked for evening which contained 3 Haldol tablets and a bedtime one which contained 2 Haldol tablets. The DON confirmed that there was no physician's order for the Haldol and that Resident 3 should not have had the Haldol among his medications. The DON stated that Resident 3 had returned from General Acute Care Hospital with an order for Haldol on 8/18/2025 which should have been discontinued on 9/1/2025. The DON stated that only active medications are kept in the medication cart meaning that those medications are being administered to the resident. During a concurrent interview and</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>(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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to create an individualized care for one of three sampled residents (Resident 3) with specific goals and interventions for Resident 3's fall risk. This deficient practice could have potentially resulted in Resident 3's continued falls. During a review of the admission record for Resident 3 indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), history of falling, and Hyperlipidemia (HLD- a condition in which there are abnormally high levels of lipids [fats] in the blood) During a review of history and physical (H&amp;P- is a thorough assessment a doctor does to understand a patient's health. It involves asking about the patient's past and current health problems [the history] and then examining the patient's body to look for signs of illness [the physical examination], dated 8/18/2025, indicated Resident 3 Family Member (FM) 1 as the responsible party. The same H&amp;P indicated Resident 3 had been admitted to General Acute Care Hospital (GACH) due to an unwitnessed fall and suffered a 1.5-centimeter (cm) laceration above the right eyebrow. During a review of Resident 3 's Minimum Data Set (MDS - a resident assessment tool) dated 8/5/2025, indicated Resident 3 had severe cognitive impairment (a person has great difficulty with thinking, learning, remembering, and making decisions, to the point where they can't live independently). The same MDS indicated Resident 3 mostly required substantial/maximal assistance for his Activities of Daily Living such as: (ADLs- routine tasks/activities such as oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, lower/upper body dressing, putting on/taking off footwear). During a review of the physician's order dated 8/18/2025, the order indicated Resident 3 may have low bed and floor mats for fall risk both left and right side. During a review of Resident 3's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 8/23/2025 at 2:10 pm, indicated, Resident is Alert &amp; orient (a medical term used to describe a person's level of consciousness and cognitive function) x2 (oriented to person and place: Knows their own name and where they are) respiration Even. Resident had unwitnessed fall. During a review of Resident 3's SBAR dated 8/31/2025 at 8:50 pm, indicated, Supervisor was called to room A by CN (Charge Nurse). Upon entering the room, found resident (Resident 3) sitting on the floor inside the bathroom facing the sink. Initial assessment made. Assisted back to bed by 2 person assist and made comfortable. During a review of Resident 3's care plan initiated 8/23/2025 indicated a focus of Actual incident of fall: UNWITNESSED FALL, with interventions including:- Frequent visual monitoring- Place call light within easy reach- Apply restraint as ordered- Encourage resident not to get up without assistance- Monitor for changes in LOC and report to MD promptly During a review of Resident 3's care plan initiated 8/31/2025 indicated a focus of un-witnessed fall, with interventions including:- Provide a safe environment, free of clutters, floor kept dry and non-slippery, rooms with adequate lighting and document changes in gait to MD- Report and document changes in gait to MD During a concurrent observation and interview of Resident 3 with Certified Nursing Assistant (CNA) 1 on 9/5/25 at 10:40 am, Resident 3 was noted to be fast asleep in a reclining chair which was at the foot of his bed against the wall. The resident was noted to have several bruises and scabs to both his arms and legs. CNA 1 confirmed that Resident 3 was a fall risk and had previously fallen in the past. CNA 1 stated that interventions to prevent residents who were at high risk for falls included frequent checks, placing the call light within reach, placing bed in the lowest position, and placing floor mats on both sides of the bed. CNA 1 confirmed that there were no floor mats on either side of Resident 3's bed. During an interview with the Director of Nursing (DON) on 9/5/2025 at 2:30 pm, the DON stated that Resident 3 was at high risk for falls and had fallen twice since his admission. She stated that when residents are at a fall risk, the interventions must include frequent visual monitoring, call light within reach, floor mats in place. The DON confirmed that there was a physician's order to place floor mats besides but that the order was not carried out nor was it included in the care plan. The DON stated that the facility should have developed an individualized care plan for fall prevention which should have included Resident 3's specific interventions such as floor mats and frequent monitor checks. The DON stated that care plans help health care staff be uniform in carrying out interventions to prevent falls. During a review of the Policy and Procedure (P&amp;P) titled Care Plans - Comprehensive, revised 12/2024, indicated the following policy statement, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental</p>		