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	12/17/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to follow professional standards of practice by failing to manage, assess and monitor resident and implement the facility policy and procedure (P&P) titled, Nursing Care of the Older Adult with Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), for one of three sampled residents (Resident 2), when resident had a hyperglycemia (high blood sugar, occurs when there's too much glucose in the blood, often because the body lacks enough insulin or can't use it properly).This deficient practice placed Resident 2 at risk of developing complications due to inadequate monitoring of blood glucose.Findings:During a review of the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type II DM, DM, End Stage Renal Disease (ESRD - irreversible kidney failure), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling).During a review of the Minimum Data Set (MDS - resident assessment tool) dated 9/27/2025, indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 2 required supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 2's Order Summary Report (OSR), dated 11/25/2025, the OSR indicated, insulin glargine (a long-acting insulin used to manage blood sugar levels) subcutaneous (SQ - a shot given into the fatty layer right under the skin, not into a muscle, using a small needle for slow, steady medicine absorption) solution 100 unit/millimeter (ml - unit of measurement) - inject four unit SQ in the morning.During a review of Resident 2's Medication Administration Record (MAR), dated 11/26/2025 at 6:30 a.m., the MAR indicated, Resident 2's blood sugar (BS) level was 348 milligram per deciliter (mg/dl - unit of measurement).During a review of Resident 2's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 11/26/2025 at 1:05 p.m., the SBAR indicated, Resident 2 was found unresponsive, lethargic (decrease in consciousness), not easily arose, breathing noted to be labored. blood pressure (BP - measures the force of blood against artery walls) 156/90 (a BP of 156/90 is considered high BP), pulse (heart beat counted per minute) 86 beats per minute (bpm), temperature 97.2 degrees Fahrenheit (F - temperature scale) and respiration (RR - breathing rate) 20.During a concurrent interview and record review with Licensed Vocational Nurse (LVN 3) on 12/16/2025 at 1:23 p.m., LVN 3 stated, in the morning of 11/26/2025, Resident 2 was sleeping and did not touch his (Resident 2) breakfast, but he usually was up early in the morning and would eat his breakfast. LVN 3 stated, Resident 2 struggled waking up and he was unable to open his eyes. LVN 3 reviewed Resident 2's MAR on 11/26/2025 at 6:30 a.m., and stated, she was not made aware of Resident 2's BS of 348 mg/dl. LVN 3 stated, there was no report given to her during hands-off from Licensed Vocational Nurse 6 (LVN 6) in the morning of 11/26/2025. LVN 3 further stated, she checked Resident 2's BS upon assessment that he was lethargic, and he had a BS of 70 mg/dl which means hypoglycemic (low blood sugar). LVN 3 reviewed SBAR on 11/26/2025 and stated, she did not document the BS of 70 mg/dl and she should have documented it.During an interview with LVN 6 on 12/16/2025 at 3:12 p.m., LVN 6 stated, she checked Resident 2's BS on 11/26/2025 at 6:30 a.m. and he had a high BS. LVN 6 stated, she administered glargine insulin, but she did not recheck his BS after administering the insulin. LVN 6 stated, she also did not give any hand-off report to the oncoming nurse regarding Resident 2's high BS and she did not document what her interventions upon assessing Resident 2's high BS. LVN 6 further stated, I honestly don't remember what I did but I should have rechecked his (Resident 2's) BS and notify the physician and the oncoming nurse and documented it.During an interview with Director of Nursing (DON) on 12/17/2025 at 2:26 p.m., DON stated, if resident has a high BS and license nurse administered insulin, they need to recheck the BS because residents who are given insulin are at risk of hypoglycemia. DON stated, Resident 2's had symptoms of hypoglycemia on 11/26/2025 as he was lethargic, unable to be aroused and unresponsive. DON further stated, the facility staff failed to document the interventions and did not notify the physician upon assessment of BS of 348 mg/dl.During a review of the facility's P&P titled, Nursing Care of the Older Adult with Diabetes Mellitus, revised on 12/2024, the P&P indicated that, The target range for healthy older adults is considered 90-130 mg/dl. The provider will order the frequency of glucose monitoring and establish appropriate glycemic targets for individual residents

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), who was assessed as high risk for falls and dependent in Activities of Daily Living (ADLs), did not experience multiple falls, one resulting in injury, by failing to: 1. Initiate an individualized plan of care upon admission on [DATE] when Resident 1 was identified as having a high fall risk. 2. Update the care plan and interventions when Resident 1 had an unwitnessed fall on 11/16/2025. 3. Ensure staff adhered to the facility's policy and procedure titled Falls - Clinical Protocol (revised 12/2024), which requires staff and physicians to identify and implement interventions to prevent falls and mitigate clinically significant consequences. 4. Evaluate and analyze hazards and risks following repeated unwitnessed falls. As a result of these failures, Resident 1 had multiple unwitnessed falls (11/16/2025, 11/23/2025) and on 12/1/2025 Resident 1 slid from the bed, landing face down on the floor, resulting in a three cm laceration to the left forehead. Resident 1 was transferred to a General Acute Care Hospital (GACH) 1 on 12/2/2025 for generalized pain following the fall, with diagnoses of thoracic spine strain (discomfort in the mid-back, between the shoulder blades and lower ribs, often caused by muscle strain, poor posture, overuse, or joint issues, though more serious causes like nerve compression or fractures exist) and left shoulder contusion (bruise from direct impact, causing pain, swelling, stiffness, and discoloration [black-and-blue] as blood vessels leak under the skin). During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnosis that included acute respiratory failure with hypoxia (severe, sudden condition where the lungs can't get enough oxygen into the blood), other lack of coordination, and other abnormalities of gait (a manner of walking or moving the foot) and mobility (ability to move arounds freely and easily). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 11/17/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills were severely impaired. The MDS indicated Resident 1 was dependent on oral hygiene, toileting, bathing and dressing. The MDS indicated Resident 1 was also dependent with mobility, helper does all of the effort, with Resident 1 laying on back to roll left and right side, sit on side of bed to lying flat on the bed, lying on the back to sitting on the side of the bed and with no back support, come to a standing position from sitting and transfer to and from a bed to chair. The MDS also indicated Resident 1's ability to get on and off a toilet commode was not attempted due to medical conditions or safety concerns. During a record review of Resident 1's fall risk assessment dated [DATE], the fall risk assessment indicated score of 14. According to the falls assessment tool, if the total score is above 10, the resident should be considered high risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan. During a record review Resident 1's admission care plan, for the admission date 11/11/2025, unable to locate documentation of a high risk for fall care plan, no care plan initiated and no intervention in place. During a review of Resident 1's Situation, Background, Assessment, Request (SBAR-communication framework widely used in healthcare to ensure clear, concise, and organized information exchange among team members.) Communication Form, dated 11/16/2025 timed at 4:16 a.m., the SBAR indicated Resident 1 slid out of bed and found sitting on the floor at bedside with no visible injuries or bruises noted and Resident 1 denied any acute pain. During a record review of Resident 1's fall risk assessment dated [DATE], indicated score of 19.During a review of review of the care plan titled Resident 1 noted sliding out of bed, dated 11/16/2025, the care plan intervention indicated fall precautions implemented such as bed at lowest locked position and frequent visual checks done by staff to ensure safety and monitoring. During review of Resident 1's care plan titled, Risk for fall initiated 11/17/2025, the care plan indicated anticipate and meet Resident 1's needs, Resident 1 needs prompt response to all request for assistance and follow facility fall protocol. During review of Resident 1's Occupational Treatment (OT) Encounter Notes, dated 11/17/2025, the notes indicated Resident 1's functional status as total dependence with dressing, toileting and bathing and unable to sit or stand during ADL. The notes indicated Resident 1 required extra time to initiate and complete given task. The notes also indicated that Resident 1's cognitive status and nursing care required were complexities and barriers impacting OT therapy session. During a review of Resident 1's SBAR Communication Form, dated 11/23/2025 timed at 9:06 p.m., the SBAR indicated Resident 1 was found on the floor by his bedside. During a review of Resident 1's SBAR Communication Form, dated 12/1/2025 timed at 10:30 p.m., the SBAR indicated a loud sound came from Resident 1's room and Resident 1 was found lying on the floor on his left