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	03/09/2026

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 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** Based on interview and record review, the facility failed to ensure two of four sampled residents (Resident 1 and Resident 2) who were admitted in the facility with pressure ulcer/injury (damaged skin caused by staying in one position for too long) received care and services to promote wound healing by failing to:1. Ensure the wound care treatment were documented with complete assessments in Resident 1 and Resident 2's medical record as indicated in the facility's policy and procedures (P&P) titled, Dressings, Dry/Clean, and Wound Care.2. Ensure the medication Calcium Alginate (a natural, seaweed-derived dressing used for heavily draining wounds) was in place for Resident 1's skin treatment.3. Follow-up on wound care specialist (WCS) order and plan of care with Resident 2's skin treatment and wound management.These deficient practices placed the residents at risk of poor wound healing and deterioration of current pressure ulcers/injury.Findings:During a review of the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection), malignant neoplasm of breast (a group of diseased cells that have grown out of control within the breast tissue, forming a tumor that can invade surrounding tissues or spread to other parts of the body) and cellulitis (a skin infection that causes swelling and redness) of right upper limb (right arm).During a review of the Minimum Data Set (MDS - resident assessment tool) dated 2/16/2026, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 1 was totally dependent on 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 1's WCS Progress Notes, dated 2/13/2026, the Progress Notes indicated that Resident 1 has an advanced breast cancer with fungating malignant chest wall mass (a type of advanced cancer growth that breaks through the skin), right heel unstageable pressure injury (a deep, severe skin wound where the base is completely covered by dead tissue), right buttock unstageable pressure injury and right scapula (shoulder blade) unstageable pressure injury. The Progress Notes by WCS also indicated plan treatment to apply silver alginate dressing on the fungating chest wall mass and right gluteal (buttock), right heel and right scapulaDuring a review of Resident 1's Order Summary Report (OSR), as of 3/6/2026, there was no order in place for Calcium Alginate for wound dressing and there was no order in place for wound dressing treatment as needed.During an interview with Treatment Nurse 2 (TXN 2) on 3/6/2026 at 11:57 a.m., TXN 2 stated, Resident 1's wound dressing would be soaking with blood and with drainage when he comes during the start of his shift (morning). TXN 2 stated, he changes Resident 1's wound dressing once daily.During a review of Resident 1's Wound Care Form, dated 2/13/2026 and 2/20/2026, there was no assessment of the wound documented and recorded in Resident 1's medical record.During a review of Resident 1's Treatment Administration Record (TAR) for the month of 2/2026, there was no treatment order for Calcium Alginate and there was no skin treatment order as needed when wound dressing gets soiled/dirty.During an interview with Director of Nursing (DON) on 3/9/2026 at 1:45 p.m., DON stated, when a wound dressing gets soiled and dirty, they must change the dressing as needed. DON stated, they should also follow up on WCS's skin treatment order, and the medications (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	must be in place. DON further stated, they don't have a complete document of Resident 1's wound assessment during wound care management as indicated in the P&Ps.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 cellulitis of buttock, hidradenitis suppurativa (chronic, non-contagious skin condition that causes painful, recurring lumps, boils, or abscesses), and candidiasis (a yeast infection that occurs when a type of yeast called Candida albicans grows out of control).During a review of the MDS dated [DATE] indicated Resident 2's cognitive skills for daily decisions were intact. The MDS indicated Resident 2 was totally dependent on staff for ADLs.During a review of Resident 1's Order Summary Report dated, 1/24/2026, the OSR indicated skin treatment order of:pack bilateral hips with saline (NS - a sterile mixture of salt and water designed to gently clean wounds, remove debris, and flush out bacteria without irritating tissues) moistened kerlix (a specialized, highly absorbent, and breathable, fluffy gauze bandage roll used to wrap wounds, burns, or pack deep wounds) then cover with ABD pads (Abdominal Pad or Army Battle Dressing) is a large, thick, highly absorbent, and sterile bandage used for covering deep or heavily draining wounds), one time a day for wound managementxeroform oil emulsion (a sterile, non-adhering wound dressing consisting of fine-mesh gauze) gauze external pad - apply to sacrum (a large, triangular bone located at the base of the spine, just above the tailbone) topically one time a day for wound management, cleanse with NS, pat dry, apply xeroform and cover with dry dressing (DD).During a review of Resident 2's WCS Progress Notes dated 1/30/2026, the Progress Notes indicated that, Resident 2's plan treatment for wound management to change dressing twice daily (BID) or as needed if soiled.During a review of Resident 2's Treatment Administration Record (TAR) dated, there was no treatment order for Calcium Alginate and there was no skin treatment order as needed when wound dressing gets soiled/dirty.During a review of Resident 2's Wound Care Form, dated 1/30/2026, 2/6/2026, 2/13/2026 and 2/20/2026, there was no assessment of the wound documented and recorded in Resident 2's medical record.During a review of Resident 2's OSR as of 3/6/2026, the wound management skin treatment order was only for daily wound dressing and there was no order for skin treatment as needed if the wound dressing is soiled.During an interview with TXN 2 on 3/6/2026 at 12:10 p.m., TXN 2 stated, Resident 2 has multiple wounds that constantly drain with yellowish, pinkish discharge color that were visible in the wound dressing. TXN 2 stated, he changes the wound dressing once daily and when he comes to work in the morning, the ABD wound dressing will have drainage and wet.During an interview with DON on 3/9/2026 at 1:45 p.m., DON stated they are not following the WCS plan of treatment for wound management. DON further stated, they don't have a complete document of Resident 2's wound assessment during wound care management as indicated in the P&Ps.During a review of the facility's policy and procedures (P&P) titled, Dressings, Dry/Clean, revised on 1/2026, the P&P indicated that, The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: the date and time the dressing was changed, wound appearance, including wound bed, edges, presence of drainage. all assessment data obtained when inspecting the wound, how the resident tolerated the procedure .During a review of the facility's P&P titled, Pressure Ulcers/Skin Breakdown, revised on 1/2026, the P&P indicated that, the staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleaning and debridement approaches, dressings, and application of topical agents.During a review of the facility's P&P titled, Wound Care, revised on 1/2026, the P&P indicated that, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following information should be recorded in the resident's medical record:The type of wound care givenThe date and time the wound care was given.The position in which the resident was placed.The name and title of the individual performing the wound care.Any change in the resident's conditionAll assessment data obtained when inspecting the wound.How the resident tolerated the procedure.Any problems or complaints made by the resident (continued on next page)

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