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	05/29/2026

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively manage the pain level for one of four sampled residents (Resident 1) according to the facility's policy and procedures (P&P), titled, Pain Assessment and Management, by failing to: -Ensure the licensed nurses (in general) followed up with the facility's Medical Director after the attending physician did not respond regarding Resident 1's left flank (the side area of the body between the rib cage and the hip) pain and Resident 1's refusal to take acetaminophen (over-the-counter medication used to lower a fever and relieve mild to moderate pain) on 5/13/2026 to 5/15/2026. This failure had the potential for Resident 1's pain level not to be controlled.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/13/2026 with diagnoses including type II Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), malignant neoplasm of female genital organs (refers to cancer originating in the female reproductive system), and hemorrhage of the anus and rectum (rectal bleeding), During a review of Resident 1's General Acute Care Hospital 2 (GACH 2)'s History and Physical (H&P), dated 5/2/2026, the H&P indicated, Resident 1's would receive Dilaudid (a very strong prescription narcotic painkiller used to treat severe pain) 0.5 milligram (mg - unit of measurement) intravenous push (IVP - injection of medication directly into the bloodstream) every four hours as needed. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool) dated 5/15/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact. The MDS indicated Resident 1 required moderate assistance 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 1's Pain Risk assessment dated [DATE], the Pain Risk Assessment indicated Resident 1 had a score 12 (high risk for potential pain). During a review of Resident 1's Pain Assessment Form dated 5/13/2026, the Pain Assessment Form indicated Resident 1 had experienced pain in the lower abdomen area due to vulvar (external park of female genitalia) cancer with intensity of 7-8/10 (pain scale categorized as severe pain), and Resident 1 reported acceptable level pain is 0/10 (pain scale categorized as no pain). The Pain Assessment Form indicated Resident 1's pain management plan was to notify the physician if current regimen was ineffective for further care. During a review of Resident 6's Order Summary Report dated 5/13/2026, the Order Summary Report indicated for Resident 1 to receive gabapentin (calms overactive nerves, it is primarily used to stop seizures [a sudden, uncontrolled electrical disturbance in the brain] and treat chronic nerve pain) 300 milligrams (mg, a unit of measurement) one capsule by mouth every 12 hours for pain management. During a review of Resident 6's Order Summary Report, the Order Summary Report dated 5/14/2026, the Order Summary Report indicated for Resident 1 to receive acetaminophen oral tablet 650 mg every six hours for pain and fever. During a review of Resident 1's Progress Notes dated 5/14/2026 at 2:23 PM, the Progress Notes indicated Resident 1 refused to take acetaminophen when offered. Sent text to Nurse Practitioner (NP 1) to see if she (Resident 1) can have stronger pain medication. Awaiting response. During a review of Resident 1's Progress Notes dated 5/14/2026 at 11:03 PM, the Progress Notes indicated Resident 1 refused. She (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident 1] stated that medication does not give me any relief. Registered Nurse (RN) supervisor made aware and in contact with the doctor. Awaiting MD order. During a review of Resident 1's Progress Notes dated 5/14/2026 at 11:22 PM, the Progress Notes indicated Resident 1 complained of pain but refused to take Tylenol (acetaminophen). The Progress Notes indicated the Medical Doctor (MD) was notified and waiting for new order for pain. During a review of Resident 1's Progress Notes dated 5/15/2026, the Progress Notes indicated that Resident 1 was noted with complained of intractable pain [severe, constant pain] at left flank [pain on the side between the ribs and the hip]. notified MD), transferred to GACH 1 via 911 (emergency phone number used to quickly reach local police, firefighters, or medical responders during an immediate crisis) due to left flank intractable pain.During an interview on 5/28/2026 at 1:38 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that on 5/14/2026 during the morning shift Resident 1 reported severe pain and refused to take acetaminophen because Resident 1 reported, it didn't do anything for her and it's not going to work. LVN 1 stated there was no other pain medication order for Resident 1 complained of severe pain. LVN 1 stated she (LVN1) contacted Resident 1's NP for an order of other pain medication and she (LVN1) reported it to the oncoming nurse (afternoon shift) to follow-up. LVN 1 stated Resident 1 received Dilaudid IVP medication at GACH 2 for severe pain and Resident 1's current pain regimen of acetaminophen and gabapentin are medications for mild to moderate pain. During a concurrent interview and record review with LVN 2 on 5/28/2026 at 2:57 PM, LVN 2 stated in the morning of 5/15/2026, Resident 1 called 911 because of her (Resident 1) complaint of severe pain. LVN 2 stated they were awaiting from the physician's response for other pain medication and no response from Resident 1's MD since 5/14/2026. During a concurrent interview and record review with Director of Nursing (DON) on 5/6/2025 at 3:01 PM, the DON stated staff must contact facility's Medical Director if resident's attending physician did not respond to their message. The DON reviewed the internal mobile phone messaging to Resident 1's attending physician and stated staff (unidentified) sent messages regarding Resident 1's complaint of severe pain and a requested for another pain medication relieve regimen on 5/14/2026 at 2 PM. The DON stated Resident 1 complained of 7-8/10 pain level and on 5/15/2026 at 12:25 AM. The DON stated staff (unidentified) messaged Resident 1's attending physician regarding Resident 1 was not able to sleep and to please prescribe a stronger pain medications. The DON stated there was no response by the attending physician and there was no attempted contact to the Medical Director on 5/14/2026 at 5/15/2026. The DON reviewed Resident 1's attending physician's message on 5/15/2026 at 7:15 AM and stated the attending physician responded for an order for Norco (used to treat moderate to severe pain when other medications do not work) 5 mg every four hours as needed and morphine sulfate (MS contin used to manage severe and persistent pain) 15 mg bid (twice daily) scheduled. The DON reviewed Resident 1's physician order and progress notes and stated there was no order placed for Norco and MS contin and there was documentation that staff received an order for Norco and MS contin. During a review of the facility's P&P titled, Pain Assessment and Management, revised on 1/2026, the P&P indicated, If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Report the following information to the physician or practitioner: significant changes in the level of the resident's pain. prolonged, unrelieved pain despite care plan interventions.