

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  06/19/2025
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</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 provide care in a manner that promoted or enhanced a resident's dignity for two of three sampled residents (Resident 6 and Resident 492) by failing to ensure to:</p> <ol style="list-style-type: none"> <li>1. Provide Resident 6 with a privacy curtain (cloth barriers that surround a patient's bed) of adequate length.</li> <li>2. Provide a cover for Resident 492's urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) bag.</li> </ol> <p>These failures had the potential to cause emotional distress, affect the Resident 6's and Resident 492's self-esteem (how we value and perceive ourselves), and cause a loss of dignity (the quality or state of being worthy, honored, or respected) and decline in psychosocial (social factors and individual thought and behavior) wellbeing.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 6's admission Record, the admission Record indicated the facility admitted the resident on 6/24/2024 with diagnoses that included encephalopathy (brain damage that causes severe confusion and forgetfulness), dysphagia (difficulty swallowing), schizophrenia (a mental illness that is characterized by disturbances in thought), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living), and lack of coordination (inability to smoothly and accurately control body movements).</li> </ol> <p>During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool) dated 4/30/2025, the MDS indicated the resident had severely impaired cognition (a significant decline in mental abilities, affecting a person's ability to think, remember, learn, make decisions, and solve problems). The MDS indicated Resident 6 required partial/moderate assistance for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 6 was dependent on help for toileting hygiene, showering and bathing herself, lower body dressing, putting on and taking off footwear, and personal hygiene.</p> <p>(continued on next page)</p>

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 6/19/2024 at 8:57 AM, with Restorative Nurse Assistant 2 (RNA 2), in Resident 6's room, RNA 2 was observed pulling Resident 6's privacy curtain to assist the resident to perform Range of Motion (ROM, exercises designed to maintain or improve the flexibility of joints and muscles) exercises. Resident 6's privacy curtain was observed short and unable to fully provide the resident with privacy. RNA 2 stated Resident 6's privacy curtain was too short. RNA 2 stated Resident 6's privacy curtain needed to be longer to provide the resident with adequate privacy.</p> <p>During a concurrent observation and interview on 6/19/2024 at 9:10 AM, with Maintenance Director 1 (MAD 1), in Resident 6's room, the resident's privacy curtain was observed. MAD 1 stated Resident 6's privacy curtain was too short and would not fully cover the resident when needed. MAD 1 stated Resident 6's privacy curtain needed to be longer to provide the resident with adequate privacy.</p> <p>During an interview on 6/19/2025 at 11:40 AM, with the Director of Nursing (DON), the DON stated each resident should have a privacy curtain to maintain dignity. The DON stated the curtain should be of adequate length to cover the resident's living area and space. The DON stated there was a potential for Resident 6's dignity to not be maintained if the privacy curtain was not an adequate length.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Dignity dated 12/2024, the P&amp;P indicated Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p> <p>2. During a review of Resident 492's admission record, the admission Record indicated the facility originally admitted Resident 492 on 11/13/2018 and readmitted the resident on 6/12/2025 with diagnoses of infection and inflammatory (the body's response to injury or infection) reaction due to indwelling urethral catheter (a thin, hollow tube inserted through the that lets urine leave the body into the urinary bladder [part of the body that stores urine] to collect and drain urine), dementia (a progressive state of decline in mental abilities), urinary tract infection (UTI- an infection in the bladder/urinary tract), and benign prostatic hypertrophy (BPH - also known as an enlarged prostate, is a common condition where the prostate gland grows larger than normal as men age).</p> <p>During a review of Resident 492's Order sheet dated 6/12/2025, the Order sheet indicated an order for a foley catheter (a thin, flexible tube that's inserted into the bladder to drain urine).</p> <p>During a review of Resident 492's History and Physical (H&amp;P) dated 6/14/2025, the H&amp;P indicated Resident 492 was getting an intravenous (IV - through a vein), Ceftriaxone (antibiotic) 1 gram (a unit of measurement) for a UTI until 6/19/2025.</p> <p>During a review of Resident 492's MDS dated [DATE], the MDS indicated Resident 492 had the ability to understand others and make himself understood. The MDS indicted Resident 492 needed maximum assistance for toileting.</p> <p>During a review of Resident 492's Care Plan dated 6/16/2025, the Care Plan indicated Resident 492 had an indwelling catheter and the catheter bag and tubing should be positioned away from the entrance room door.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 6/16/2025 at 1:26 PM with Certified Nursing Assistant 1 (CNA 1) in Resident 492's room, the resident's urinary catheter bag was observed hanging on the bed without a cover. CNA 1 stated the urine bag was not covered and the resident's dignity (the quality or state of being worthy, honored, or respected) may be affected.</p> <p>During an interview on 6/19/2025 at 11:28 AM with the Director of Nursing (DON), the DON stated if a resident's urine bag is not covered (in general), the resident's dignity could be affected.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled Dignity, dated 12/2024, indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&amp;P also indicated Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example:</p> <p>a. helping the resident to keep urinary catheter bags covered.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</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 one of one sampled residents (Resident 126) would not be allowed to keep ear drops (Debrox drops, earwax removal kit) medication at the bedside without a physician's order.</p> <p>This failure had the potential to result in unsafe medication application and/or over medicating for Resident 126.</p> <p>Findings:</p> <p>During a review of Resident 126's admission Record, the admission Record indicated the facility admitted the resident on 3/1/2025 and readmitted on [DATE] with diagnoses that include lack of coordination, bed confinement, and history of falling.</p> <p>During a review of Resident 126's Care Plan Report, date initiated 3/3/2025, the Care Plan Report indicated the resident was at risk for adverse reaction (harmful reaction to a medicine) related to polypharmacy (is when you take several medications [five or more] each day). The Care Plan Report indicated the intervention was to ensure each physician had the full list of medications available, including OTC (over the counter) and PRN (as needed) medications.</p> <p>During a review of Resident 126's Minimum Data Set (MDS, a resident assessment tool) dated 4/27/2025, the MDS indicated the resident had an intact cognitive function (impairment in the ability to think, understand and reason).</p> <p>During a review of Resident 126's History and Physical (H&amp;P), dated 4/28/2025, the H&amp;P indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 126's Order Summary Report, dated 6/19/2025, the Order Summary Report indicated the resident had an audiology (study of hearing) consult PRN (as needed) hearing problems.</p> <p>During an interview on 6/16/2025 at 12:07 PM with Resident 126, Resident 126 stated he (Resident 126) currently had a build up of ear wax which would make it hard to hear. Resident 126 stated the ear wax medicated drops were on bedside table.</p> <p>During an observation and an interview on 6/19/2025 at 12:30PM with Resident 126, the resident was resting in bed, Debrox ear wax medication box noted at bedside. The resident stated a friend(unidentified) who visited him gave him the ear wax medication. Resident 126 stated he (Resident 126) could not remember when his friend brought the ear wax medication.</p> <p>(continued on next page)</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and an observation on 6/19/2025 at 12:57 PM with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated he (LVN6) gave Resident 126's morning medications and did not notice the Debrox ear wax medication box at bedside. LVN6 was holding medication box in his hand. LVN 6 stated friends and family needed to be educated on bringing medication into the facility because it could negatively interact with medication that were prescribed by the doctor. LVN6 stated all residents (in general) at the facility could not self-administer medications. LVN 6 stated he (LVN6) would call the doctor and ask if Debrox ear wax medication could be added to Resident 126's current medications to be administered by licensed staff.</p> <p>During an interview on 6/19/2025 at 2:18 PM with the Director of Nursing (DON), the DON stated medications need to be confined and ordered from the MD (Medical Doctor). It is dangerous if medications are at the resident's bedside because we do not know if the medication was properly sealed, if they are contraindicated or have negative interactions with medications they are currently taking.</p> <p>During a review of the facility's undated policy and procedure titled Identification of Medications Brought In At Admission, indicated Identification of medications, which are brought in from the acute care hospital, other nursing centers, Intermediate Care Center (ICF), or those medications dispensed by an outside pharmacy after admission and brought directly to the center, is not required by Del's Pharmacy. It is however, the responsibility of the center to assure correct identification of those medicines.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) discharge (the formal release from a facility) assessment was accurately performed for one of seven sampled residents (Resident 138).</p> <p>This failure had the potential to result in the inadequate care of Resident 138 during her discharge from the facility.</p> <p>Findings:</p> <p>During a review of Resident 138's admission Record, the admission Record indicated the facility admitted the resident on 3/5/2025 with diagnoses that included chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), lack of coordination (inability to smoothly and accurately control body movements), difficulty in walking, a history of falling, and a displaced fracture of the greater trochanter of the left femur (a broken left upper thigh bone).</p> <p>During a review of Resident 138's MDS dated [DATE], the MDS indicated Resident 138 was discharged to a Short-Term General Hospital (a medical center that specializes in the short-term medical treatment of patients).</p> <p>During a review of Resident 138's Order Summary Report dated 3/22/2025, the Order Summary Report indicated the resident was to be discharged to a Senior Living Facility 1 (SLF 1) on 3/22/2025 with Home Health Services (HHS, health care services that you can get in your home for an illness or injury) for nursing, physical therapy (treatment that helps improve how the body performs physical movements), occupational therapy (health care services that help improve the ability to perform daily tasks), and Durable Medical Equipment (DME, reusable medical devices used to manage health conditions, aid in recovery from injuries, or help individuals maintain independence).</p> <p>During a review of Resident 138's Discharge summary dated [DATE] at 1:16 PM, the Discharge Summary indicated Resident 138 was discharged by a private car to SLF 1 with all her medicine accompanied by her family member.</p> <p>During a concurrent interview and record review on 6/18/2025 at 2:06 PM, with MDS Assistant (MDS 1), Resident 138's MDS dated [DATE] and Order Summary Report dated 3/22/2025 were reviewed. MDS 1 stated Resident 138 was discharged to SLF 1 on 3/22/2025. MDS 1 stated the MDS dated [DATE] was inaccurate because it indicated Resident 138 was discharged to a short-term hospital. MDS 1 stated the MDS assessment must be accurate and reflect the resident's status. MDS 1 stated there was a potential for Resident 138 to not have her needs met at discharge if the MDS assessment was inaccurate.</p> <p>During a concurrent interview and record review on 6/19/2025 at 11:50 AM, with the Director of Nursing (DON), Resident 138's MDS dated [DATE] and Order Summary Report dated 3/22/2025 were reviewed. The DON stated Resident 138 was discharged to SLF 1 not a hospital. The DON stated the MDS dated [DATE] did not reflect that Resident 138 was discharged to a SLF. The DON stated a resident might not receive the appropriate care when discharged from the facility if the MDS assessment was inaccurate.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy &amp; Procedure (P&amp;P) titled Resident Assessments dated 12/2024, the P&amp;P indicated A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements .The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements .Discharge Assessment - Conducted when a resident is discharged from the facility . A comprehensive assessment includes: Completion of the Minimum Data Set (MDS); Completion of the Care Area Assessment (CAA) Process; and Development of the comprehensive care plan.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to develop an individualized person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatment) to meet the resident's needs for one of three sampled residents (Resident 44) by failing to create an appropriate care plan for Resident 44's tube feeding (a method of providing nutrition directly into the stomach or small intestine through a tube, when a person is unable to eat or drink enough to meet their nutritional needs).</p> <p>This failure had the potential for Resident 44 to receiving inadequate care.</p> <p>Findings:</p> <p>During a review of Resident 44's admission Record, the admission Record indicated the facility admitted the resident on 9/16/2024 and readmitted on [DATE] with diagnoses that include hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body) following cerebral infarction affecting right dominant side, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia (difficulty swallowing), gastro-esophageal reflux disease (when the stomach acid frequently flows back into the esophagus, causing heartburn and other issues) and muscle weakness.</p> <p>During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool) dated 4/4/2025, the MDS indicated the resident had a moderate cognitive impairment (impairment in the ability to think, understand and reason). The MDS indicated the resident was not assessed for eating ability due to medical condition or safety concerns.</p> <p>During a review of Resident 44's Care Plan Report, date initiated 12/27/2024, the Care Plan Report indicated the resident had a Gt site on upper abdomen.</p> <p>During a review of Resident 44 ' s Order Summary Report, with an order date of 4/3/2025, the Order Summary Report indicated for the resident to receive enteral (also referred to as tube feeding, is the delivery of nutrients through a feeding tube directly into the stomach) feeding with Glucerna 1.5 (nutrition formula) at 60 milliliters (mL, a unit of measurement) per hour for 20 hours to equal 1,200 mL /1800 kilocalorie (Kcal, a unit of energy measurement commonly used in nutrition to express the energy content of food) via the ePump machine (a system is intended for when patients require nutrition through continuous feeding, intermittent feeding or feeding and flushing) two times a day at 12PM and off at 8AM or until total desired volume was infused.</p> <p>During an interview on 6/18/2025 at 9:38 AM with the Licensed Vocational Nurse (LVN) charge nurse, LVN stated he was searching for g-tube care plans related to the g-tube feeding and stated he (LVN charge nurse) was having difficulty finding them.</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>During a concurrent interview and record review on 6/18/2025 at 12:21 PM with the Director of Nursing (DON), the DON stated Resident 44's care plan for g-tube was important so that staff would know how to care for the resident. The DON stated the Care plan for g-tube on upper abdomen was printed and was searching for another care plan regarding g-tube regarding feeding.</p> <p>During an interview on 6/19/2025 at 3:01 PM with the DON, the DON presented another careplan for Resident 44, the resident requires tube feeding (G-TUBE) related to dysphagia (difficulty swallowing). Date initiated 6/19/2025, today's date.</p> <p>During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered dated December 2024, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. During a review of Resident 45's order for diclofenac sodium (a medication used to relieve pain and inflammation in certain joints) external gel 1 %, the order (dated 8/24/2024) indicated apply to both [hands] topically two times a day for pain management.</p> <p>During an observation on 6/18/25 at 8:49 AM, Licensed Vocational Nurse (LVN 3) applied the diclofenac gel to both of Resident 45's knees.</p> <p>During an interview on 6/18/2025 at 11:32 AM, the Director of Nursing (DON) stated Resident 45's diclofenac gel order was written for the application to the hands and the nurse should contact doctor if Resident 45 had pain in the knees.</p> <p>During an interview, and a concurrent review of Resident 45's medication administration record (MAR) of June 2025, on 6/18/2025 at 12 PM, the DON reviewed Resident 45's MAR for the diclofenac gel. The DON stated the hans in the order was misspelled and should be hands. The MAR indicated that at least four of 17 morning applications of diclofenac with the sites of applications noted as BLE (both lower extremities/legs) and there was no documented site of evening applications. The DON stated BLE meant bilateral lower extremities. The DON stated nurses (in general) should only apply the medication to the area stipulated in the order, otherwise, nurses needed to contact the doctor for changes in order and evaluation of resident's new pain area.</p> <p>During a review of Resident 45's care plan (initiated on 10/9/2023) did not specific which joints required pain management.</p> <p>During an interview on 6/18/25 at 3:37 PM, the DON presented a clarification order (dated 6/18/2025) and a revised care plan (dated 6/18/25) for Resident 45, however, during a concurrent review of the care plan, the DON stated there was no new interventions added to the care plan.</p> <p>3. During a review of Resident 44's admission Record, the admission Record indicated the facility admitted the resident on 9/16/2024 and readmitted on [DATE] with diagnoses that include hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body) following cerebral infarction affecting right dominant side, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gastrostomy (Gtube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia (difficulty swallowing), gastro-esophageal reflux disease (when the stomach acid frequently flows back into the esophagus, causing heartburn and other issues) and muscle weakness.</p> <p>During a review of Resident 44's Care Plan Report, date initiated 12/27/2024, the Care Plan Report indicated the resident has a Gt (Gtube) site on upper abdomen. Target date: 4/11/2025</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 44 ' s Order Summary Report, with an order date of 4/3/2025, the Order Summary Report indicated for the resident to receive enteral (also referred to as tube feeding, is the delivery of nutrients through a feeding tube directly into the stomach) feeding with Glucerna 1.5 (nutrition formula) at 60 milliliters (mL, a unit of measurement) per hour for 20 hours to equal 1,200 mL / 1800 kilocalorie (Kcal, a unit of energy measurement commonly used in nutrition to express the energy content of food) via the ePump machine (a system is intended for when patients require nutrition through continuous feeding, intermittent feeding or feeding and flushing) two times a day at 12 PM and off at 8 AM or until total desired volume was infused.</p> <p>During a review of Resident 44's MDS dated [DATE], the MDS indicated the resident had a moderate cognitive impairment (impairment in the ability to think, understand and reason). The MDS indicated the resident was not assessed for eating ability due to medical condition or safety concerns.</p> <p>During a concurrent interview and record review on 6/18/2025 at 12:21 PM with the Director of Nursing (DON) Resident 44's care plans for g-tube were reviewed. The DON stated Resident 44's care plans needed to be revised so the nursing staff would know how to care for the resident.</p> <p>4. During a review of Resident 68's admission Record, the admission Record indicated the facility admitted the resident on 8/2/2021 and readmitted on [DATE] with diagnoses that include seizures, altered mental status, depression (a mental health disorder characterized by a persistent feeling of sadness and loss of interest in activities, impacting how someone feels, thinks and behaves), schizophrenia (a mental illness that is characterized by disturbances in thought), mild cognitive impairment (impairment in the ability to think, understand and reason), epilepsy (a neurological condition characterized by recurrent, unprovoked seizures), and encephalopathy (a condition where the brain does not function properly).</p> <p>During a review of Resident 68's MDS dated [DATE], the MDS indicated the resident had a moderate cognitive impairment (impairment in the ability to think, understand and reason). The MDS indicated the resident also had fluctuating disorganized thinking and altered level of consciousness.</p> <p>During a review of Resident 68's Care Plan Report, date initiated 5/15/2025, the Care Plan Report indicated, the resident has a seizure disorder (Epilepsy) and is to have the following medication(s): Levetiracetam (medication to help treat seizures) oral tablets 1000 milligrams (mg, a unit of measurement) to be given BID (twice a day). The Care Plan Report indicated Resident 68 had three episodes of seizure activity. Revised on 1/16/2025.</p> <p>During an interview on 6/18/2025 at 12:15PM with LVN charge nurse, LVN stated, Resident 68 was on seizure precautions, the bed was always in the lowest position.</p> <p>During an interview on 6/18/2025 at 12:20 PM with the DON, DON stated, Resident 68's care plans for falls, behaviors and seizure precautions were important to be revised so that we know how to care for the patient and revise as needed.</p> <p>During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered dated December 2024, indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' condition change.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  LA Brea Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  505 N. LA Brea Avenue Los Angeles, CA 90036	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to revise the care plans for four of ten sampled residents (Resident 42, Resident 44, Resident 45, and Resident 68) by failing to revise:</p> <ol style="list-style-type: none"> <li>1. Resident 42's low air loss mattress (LALM - a specialized air mattress designed to prevent pressure injuries (PI, injuries to the skin and underlying tissue resulting from prolonged pressure on the skin) care plan.</li> <li>2. Resident 45's new pain area care plan.</li> <li>3. Resident 44's gastrostomy tube (g-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) care plan.</li> <li>4. Resident 68's behavioral and seizure (a sudden, uncontrolled electrical disturbance in the brain) precaution care plan.</li> </ol> <p>These failures had the potential to negatively affect the provision of care and services for Resident 42, Resident 44, Resident 45, and Resident 68.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of pressure ulcer stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) left hip, pressure ulcer stage 4 right upper back, dementia (a progressive state of decline in mental abilities), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).</li> </ol> <p>During a review of Resident 42's History and Physical (H&amp;P) dated 11/2/2024, the H&amp;P indicated Resident 42 was immobile (unable to move) and had multiple wounds in her upper back and left hip stage 4 wound. The H&amp;P indicated a specialty mattress. The H&amp;P indicated Resident 42 lacked the capacity to make and understand decisions (a person has the mental ability to understand and make choices about their own life and affairs).</p> <p>During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool) dated 5/31/2025, the MDS indicated Resident 42 rarely/never understood others and rarely/never had the ability to make herself understood. The MDS indicated Resident 42's ability to make daily decisions was severely impaired. The MDS indicated Resident 42 was dependent for toileting, showering/bathing, rolling left and right, and for personal hygiene (keeping your body clean to stay healthy and avoid spreading germs).</p> <p>During a review of Resident 42's Order Summary Report dated 6/19/2025 indicated Resident 42's physician wrote an order for Low Air Loss Mattress for wound management. Firmness: Resident current weight. Mode: Normal Pressure Check Daily every day shift for pressure relieving mattress for decub (bed sore) mgt (management).</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an concurrent observation and interview on 6/16/2025 at 11:30 AM with Licensed Vocational Nurse 6 (LVN 6), Resident 42's LALM setting was observed to be set at 350. LVN 6 immediately noted the setting and was observed turning the knob to a lower setting. The surveyor asked LVN 6 if he knew what the resident's weight was and LVN 6 stated he would have to check Resident 42's electronic medical record (EMR). LVN 6 stated Resident 42's weight was 142 lbs (weight was later rechecked on 6/19/2025 and Resident 42's actual weight was 162 lbs). LVN 6 stated Resident 42's LALM was not set to the correct weight when it was set to 350 and the LALM should have been set to the resident's correct weight.</p> <p>During a concurrent interview and record review on 6/19/2025 at 11:05 AM with the Director of Nursing (DON), Resident 42's Care Plan dated 10/14/2024 was reviewed. The DON stated the resident had a Stage 4 PI and was at risk to develop PIs and the nursing interventions were for the resident to have the LALM for skin maintenance. The DON stated the nursing staff did not follow the resident's care plan when they set Resident 42's LALM to 350 and the setting was too high because Resident 42 weighed 162 lbs. The DON stated when staff set the LALM to 350 it defeated the purpose of the LALM, the LALM was too hard, and could make the resident's (Resident 42) bedsores/wounds worse.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to reassess and reevaluate to identify residents' needs and/or change in conditions, for two of four observed residents (Resident 45 and Resident 89).</p> <p>This failure had the potential for medication error and/or delay in treatment that may or may not affect Resident 89 and Resident 45' conditions.</p> <p>(Cross Reference F759)</p> <p>Findings:</p> <p>a. During a med pass observation on 6/18/2025 at 8:49 AM, LVN 3 applied diclofenac sodium external gel 1 % to Resident 45's both knees. During a review of Resident 45's diclofenac order, the order (dated 8/24/2024) indicated apply to both [hands] topically two times a day for pain management.</p> <p>During a review of Resident 45's care plan and a concurrent interview on 6/18/2025 at 3:40 PM, with the Director of Nursing (DON) Resident 45's care plan was reviewed. The DON stated the care plan did not specify which joints required pain management. The DON stated there was no mention of pain in hands or knees. The DON stated there was no documented assessment regarding Resident 45's pain in the knees.</p> <p>b. During a medication administration (med pass) observation on 6/18/2025 at 8:27 AM Licensed Vocational Nurse (LVN 4) did not administer Resident 89's medication order (dated 7/16/2024) for diclofenac sodium (a medication used to relieve pain and inflammation in certain joints) external gel 1 %, with an instruction to apply to the right shoulder two times a day for pain management.</p> <p>During an interview on 6/18/2025 at 11:11 AM, LVN 4 stated Resident 89 did not ask for [diclofenac gel] .</p> <p>During an observation and a concurrent interview on 6/18/2025 at 1:10 PM, Resident 89 moved his right upper arm and shoulder in a circle and stated he had not been having any pain in the right shoulder, thus, he did not feel he needed the gel anymore.</p> <p>During an interview on 6/18/2025 at 1:30 PM LVN 4 stated Resident 89 had not needed diclofenac gel for at least two weeks. LVN 4 referred to Resident 89's MAR and stated Resident 89's pain level had been zero (no pain) for his shoulders.</p> <p>During an interview on 6/18/2025 at 1:38 PM, the DON stated nurses (in general) should reassess resident 89's right shoulder and notify the doctor for the change in condition. The DON reviewed Resident 89's care plan and stated there was no change in Resident 89's care plan regarding the shoulder pain.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility policy and procedures, Care Plans, Comprehensive Person-Centered (dated December 2024), the policy indicated . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . The comprehensive, person-centered care plan will . incorporate identified problem areas; . identify the professional services that are responsible for each element of care; . reflect currently recognized standards of practice for problem areas and conditions . interventions address the underlying source(s) of the problem area(s) . The interdisciplinary team must review and update the care plan . when there has been a significant change in the resident's condition .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to rotate the insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection (the act of putting a liquid, especially a drug, into a person's body using a needle ) administration sites for one of one sampled residents (Resident 109).</p> <p>This failure had the potential for Resident 109 to develop skin infection.</p> <p>Findings:</p> <p>During a review of Resident 109's admission Record, the admission Record indicated the facility admitted the resident on 1/3/2025 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 109's Minimum Data Set (MDS, a resident assessment tool) dated 4/19/2025, the MDS indicated the resident had moderate cognitive impairment (some impairment in the ability to think, understand, and reason). The MDS indicated Resident 109 received insulin injections.</p> <p>During a review of Resident 109's Order Summary Report dated 6/18/2025, the Order Summary Report indicated the resident had a physician order to receive Lispro Insulin (a medication used to manage type 2 diabetes by lowering blood sugar levels) per sliding scale (a chart with preestablished insulin doses used to determine the dose to be administered to an individual based on blood sugar levels) subcutaneously (a method of administering medication by injecting it into the fatty layer of tissue just beneath the skin) before meals and at bedtime for DM.</p> <p>During a review of Resident 109's Medication Administration Report (MAR) dated 5/1/2025 - 5/31/2025, the MAR indicated the resident consecutively received insulin in the right arm on 5/1/2025 at 11:30 AM and 4:30 PM; 5/25/2025 at 11:30 AM and 4:30 PM; and 5/28/2025 at 11:30 AM and 4:30 PM. The MAR indicated Resident 109 consecutively received insulin in the left arm on 5/2/2025 at 11:30 AM and 4:30 PM.</p> <p>During a review of Resident 109's MAR dated 6/1/2025 to 6/17/2025, the MAR indicated Resident 109 consecutively received insulin in the left arm on 6/2/2025 at 11:30 AM and 4:30 PM; and on 6/6/2025 at 4:30 PM and 9:00 PM. The MAR indicated Resident 109 consecutively received insulin in the right arm on 6/3/2025 at 11:30 AM and 4:30 PM.</p> <p>During a concurrent interview and record review on 6/18/2025 at 4 PM, with Licensed Vocational Nurse 5 (LVN 5), Resident 109's MAR dated 5/1/2025 to 5/31/2025 and MAR dated 6/1/2025 to 6/17/2025 were reviewed. LVN 5 stated Resident 109 did not have his insulin administration sites rotated on 5/1/2025 at 11:30 AM and 4:30 PM, 5/2/2025 at 11:30 AM and 4:30 PM, 5/25/2025 at 11:30 AM and 4:30 PM, 5/28/2025 at 11:30 AM and 4:30 PM, 6/2/2025 at 11:30 AM and 4:30 PM, 6/3/2025 at 11:30 AM and 4:30 PM, and on 6/6/2025 at 4:30 PM and 9:00 PM. LVN 5 stated when insulin was administered the injection sites should have been rotated to prevent infection.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/19/2025 at 11:45 AM, with the Director of Nursing (DON), Resident 109's MAR dated 5/1/2025 - 5/31/2025 and MAR dated 6/1/2025 to 6/17/2025 were reviewed. The DON stated Resident 109 did not have his insulin administration sites rotated on 5/1/2025 at 11:30 AM and 4:30 PM, 5/2/2025 at 11:30 AM and 4:30 PM, 5/25/2025 at 11:30 AM and 4:30 PM, 5/28/2025 at 11:30 AM and 4:30 PM, 6/2/2025 at 11:30 AM and 4:30 PM, 6/3/2025 at 11:30 AM and 4:30 PM, and on 6/6/2025 at 4:30 PM and 9:00 PM. The DON stated the injection sites needed to be rotated when administering insulin injections. The DON stated there was a potential for Resident 109 to develop cellulitis (skin infection) from repeated injections in the same area.</p> <p>During a review of the facility's Policy &amp; Procedure (P&amp;P) titled Insulin Administration dated 12/2024, the P&amp;P indicated Purpose: To provide guidelines for the safe administration of insulin to residents with diabetes .Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> c. During a review of Resident 105's admission Record, the admission Record indicated the facility admitted the resident on 11-6-2024 with diagnosis that included bed confinement status (a state where an individual is unable to leave their bed without assistance due to a medical condition, injury, or physical limitation), human immunodeficiency virus disease (HIV- a viral infection that weakens the immune system and can lead to one getting life-threatening infections), end stage renal disease (irreversible kidney failure), and actinic keratosis (a rough, scaly patch or bump on the skin caused by damage from ultraviolet (UV) radiation).</p> <p>During a review of Resident 105's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/14/2025 for a LALM every shift for wound management.</p> <p>During a review of Resident 105's MDS dated [DATE], the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 105 required partial/moderate assistance with eating. The MDS indicated Resident 105 required substantial/maximal assistance with oral hygiene, toileting hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 105 was dependent on help for lower body dressing and putting on and taking off footwear. The MDS indicated Resident 105 was at risk of developing pressure ulcers/injuries. The MDS indicated Resident 105 had one Stage 4 (a pressure ulcer characterized by full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure ulcer. The MDS indicated Resident 105 utilized a pressure reducing device for bed.</p> <p>During a review of Resident 105's Weight Summary, the Weight Summary indicated the resident weighed 140 lbs. on 6/1/2025.</p> <p>During a concurrent observation and interview on 6/19/2025 at 11:25 AM, with the DON, Resident 105's was observed on a Protekt Aire 6000 LALM. Resident 105's LALM was observed on the 230 lbs., setting. The DON stated based on Resident 105's weight of 140 lbs. the LALM settings of 230 lbs., were incorrect. The DON stated the LALM settings should be based on the resident's weight. The DON stated since Resident 105 weighed 140 lbs. his LALM setting should be at 140 lbs. The DON stated there was a potential for Resident 105 to re-develop a pressure ulcer with the LALM on the wrong settings.</p> <p>During a review of the undated operational manual titled Operation Manual for Protekt Aire 6000, the operational manual indicated Operation . It is recommended to press Auto Firm on the panel when the mattress is first inflated. Users can then easily adjust the air mattress to a desired firmness according to the patient's weight and comfort.</p> <p>Based on observation, interview, and record review, the facility failed to maintain the appropriate Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries [PU/PI, localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device]) settings for three of three sampled residents (Resident 42, Resident 93 and Resident 105).</p> <p>This failure had the potential to place Resident 42, Resident 93 and Resident 105 at risk for discomfort, slow wound healing, and the development of pressure ulcers/injuries</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Findings:</p> <p>a. During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of pressure ulcer stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) left hip, pressure ulcer stage 4 right upper back, dementia (a progressive state of decline in mental abilities), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a review of Resident 42's History and Physical (H&amp;P) dated 11/2/2024, the H&amp;P indicated Resident 42 was immobile (unable to move) and had multiple wounds in her upper back and left hip stage 4 wound. The H&amp;P indicated a specialty mattress. The H&amp;P indicated Resident 42 lacked the capacity to make and understand decisions (a person has the mental ability to understand and make choices about their own life and affairs).</p> <p>During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool) dated 5/31/2025, the MDS indicated Resident 42 rarely/never understood others and rarely/never had the ability to make herself understood. The MDS indicated Resident 42's ability to make daily decisions was severely impaired. The MDS indicated Resident 42 was dependent for toileting, showering/bathing, rolling left and right, and for personal hygiene (keeping your body clean to stay healthy and avoid spreading germs).</p> <p>During a review of Resident 42's Order Summary Report dated 6/19/2025, indicated Resident 42's physician wrote an order for Low Air Loss Mattress for wound management. Firmness: Resident current weight. Mode: Normal Pressure Check Daily every day shift for pressure relieving mattress for decub (bed sore) mgt (management).</p> <p>During an concurrent observation and interview on 6/16/2025 at 11:30 AM with Licensed Vocational Nurse 6 (LVN 6), Resident 42's LALM setting was observed to be set at 350. LVN 6 immediately noted the setting and was observed turning the nob to a lower setting. The surveyor asked LVN 6 if he (LVN6) knew what the resident's weight was and LVN 6 stated he (LVN 6) would have to check Resident 42's electronic medical record (EMR). LVN 6 stated Resident 42's weight was 142 lbs (weight was later rechecked on 6/19/2025 and Resident 42's actual weight was 162 lbs). LVN 6 stated Resident 42's LALM was not set to the correct weight when it was set to 350 and the LALM should have been set to the resident's correct weight.</p> <p>During a concurrent interview and record review on 6/19/2025 at 11:05 AM with the Director of Nursing (DON), Resident 42's Care Plan dated 10/14/2024 was reviewed. The DON stated the resident had a Stage 4 PI and was at risk to develop PIs and the nursing interventions were for the resident to have the LALM for skin maintenance. The DON stated the nursing staff did not follow the resident's care plan when they set Resident 42's LALM to 350 and the setting was too high because Resident 42 weighed 162 lbs. The DON stated when staff set the LALM to 350 it defeated the purpose of the LALM, the LALM was too hard, and could make the resident's (Resident 42) bedsores/wounds worse.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 6/19/2025 at 11:05 AM with the DON, the product manual for Resident 42's LALM titled Med-Aire Melody Alternating Pressure Low Air Loss Mattress Replacement System Operator's Manual, (manual not dated) was reviewed. The DON stated the Operator's Manual indicated Step 6 Determine the patient's weight and set the control knob to that weight setting on the control unit. The DON stated the facility did not have a policy for LALM and the facility used the manufacturer guidelines for the LALM setting. The DON stated staff were not following the manufacturer guidelines.</p> <p>b. During a review of Resident 93's admission Record, the admission Record indicated the facility admitted the resident on 12/1/2023 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells), severe-protein calorie malnutrition (a serious condition resulting from inadequate intake of both protein and calories), and a pressure ulcer of an unspecified site.</p> <p>During a review of Resident 93's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognition (some impairment in the ability to think, understand, and reason). The MDS indicated Resident 93 was dependent on help for eating, oral hygiene, toileting hygiene, upper and lower body dressing, putting on and taking off footwear, and personal hygiene. The MDS indicated Resident 93 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident 93 utilized a pressure reducing device for bed.</p> <p>During a review of Resident 59's Weight Summary, the Weight Summary indicated the resident weighed 159 pounds (lbs., a measurement of weight) on 6/2/2025.</p> <p>During a review of Resident 59's Order Summary Report, the Order Summary Report indicated the resident dated 6/18/2025, the Order Summary Report indicated the resident had a physician order for a Low Airloss Therapy bed (LALM) for prophylaxis of pressure ulcers. The Order Summary Report indicated to monitor the mode of the LALM. The Order Summary Report indicated the LALM was to be on normal pressure with firmness set per Resident 93's comfort or weight.</p> <p>During a concurrent observation and interview on 6/16/2025, at 3:32 PM, with the DON, in Resident 93's room, the resident was observed on a Protekt Aire 2000/3000 LALM. Resident 93's LALM was observed with a label that indicated the LALM settings were to be on 120 - 160 lbs. Resident 93's LALM was observed on the 200 lbs., setting. The DON stated and verified Resident 93's LALM was set at 200 lbs. The DON stated the LALM settings were incorrect. The DON stated the purpose of the LALM was to help prevent pressure ulcers from developing. The DON stated that the purpose of the LALM was defeated if it was not placed on the correct settings. The DON stated there was a potential for Resident 93 to develop a pressure ulcer with the LALM on the wrong settings.</p> <p>During a review of the undated operational manual titled Operation Manual for Protekt Aire 3000/3500/3600/3600AB, the operation manual indicated Operating Instructions . Step 6 Determine the patient's weight and set the control knob to that weight setting on the control unit.</p>		

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NAME OF PROVIDER OR SUPPLIER  LA Brea Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  505 N. LA Brea Avenue Los Angeles, CA 90036	
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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</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 provide the correct enteral tube feeding (way to get nutrients into the body through a tube that's inserted into the stomach or small intestine, bypassing the mouth) rate of 65 milliliter (mL, a unit of measure) per hour for one of three sampled residents (Resident 21).</p> <p>This failure had the potential for Resident 21 to experience malnutrition (is a serious condition that happens when a person's diet does not contain the right amount of nutrients).</p> <p>Findings:</p> <p>During a review of Resident 21's admission Record, the admission Record indicated Resident 21 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included encephalopathy (a condition where the brain does not function properly), dysphagia (difficulty swallowing), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).</p> <p>During a review of Resident 21's History and Physical (H&amp;P) dated 2/3/2025, the H&amp;P indicated Resident 21 had a diagnosis of aspiration pneumonia (a lung infection caused by inhaling food, liquid, vomit, or saliva into the lungs instead of swallowing them properly) and dementia (a progressive state of decline in mental abilities). The H&amp;P indicated Resident 21 had a g-tube (gastrostomy). The H&amp;P indicated Resident 21 lacked the capacity to make and understand decisions (a person has the mental ability to understand and make choices about their own life and affairs).</p> <p>During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 5/31/2025, the MDS indicated Resident 21 sometimes understood others and sometimes could make himself understood.</p> <p>During a review of Resident 21's Order Summary Report dated 6/19/2025, the Order Summary Report indicated Resident 21's physician wrote an order on 6/11/2025 for enteral tube feeding to run at 65 mL per hour.</p> <p>During a review of Resident 21's Progress Note dated 6/1/2025 created by Dietician 1 (DT 1), the Progress Note indicated Resident 21 was NPO (nothing by mouth). The Progress Note indicated Resident 21 had gradual weight loss in one, three, and six months. The Progress Note indicated Resident 21 recently lost five pounds and could benefit from more kcal (a unit of energy, and it's essentially the same thing as what's commonly referred to as a calorie on food labels and in discussions about diet) and protein from his tube feeding.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 6/16/2025 at 12:35 PM with Licensed Vocational Nurse 9 (LVN 9) and Registered Nurse 1 (RN 1), Resident 21's enteral tube feeding was observed to be running at 45 ml per hour on the machine and the label on the tube feeding indicated the feeding should be running at 65 mLs per hour. LVN 9 stated the enteral tube feeding label was wrong and the tube feeding machine was set correctly to 45 ml per hour. RN 1 checked the order and stated the machine should be set to 65 mL per hour. RN 1 stated when the machine was set to 45 mL per hour and the resident was at risk for malnutrition and skin breakdown. RN 1 was observed setting the machine to the correct setting of 65 mLs per hour.</p> <p>During an interview on 3/19/2025 at 10:59 AM with the Director of Nursing (DON), the DON stated Resident 21 could be at risk for malnutrition and skin breakdown if Resident 21's enteral tube feeding was set to 45 mL per hour instead of the 65 mL per hour that was ordered by the resident's physician.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled Enteral Feedings - Safety Precautions, dated 12/2024, the P&amp;P indicated the purpose of the P&amp;P was to ensure the safe administration of enteral nutrition. In the section of the P&amp;P titled preventing errors in administration, the P&amp;P indicated the staff should check the enteral nutrition label against the order before administration. Check the following information:</p> <ol style="list-style-type: none"> <li>a. Resident name, ID and room number;</li> <li>b. Type of formula;</li> <li>c. Date and time formula was prepared;</li> <li>d. Route of delivery;</li> <li>e. Access site;</li> <li>f. Method (pump, gravity, syringe); and</li> <li>g. Rate of administration (mL/hour).</li> </ol>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</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 provide an emergency kit (a special kit placed at the resident's bedside used in emergency situations such as bleeding from a dialysis fistula [surgically created connection between an artery and a vein, usually in the arm, that makes it easier to access your bloodstream for dialysis]) for two of five sampled residents (Resident 124 and Resident 491).</p> <p>This failure had the potential for Resident 124 and Resident 491 to experience uncontrollable bleeding.</p> <p>Findings:</p> <p>a. During a review of Resident 124's admission Record, the admission Record indicated Resident 124 was admitted on [DATE] with diagnoses that included diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), ESRD (End Stage Renal Disease-irreversible kidney failure, and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>During a review of Resident 124's Care Plan Report dated 3/31/2025, the Care Plan Report indicated the resident was on anticoagulant therapy (medications that stop your blood from clotting too easily) and was at risk for bleeding. The Care Plan Report indicated Resident 124 would be monitored by the facility for signs and symptoms of bleeding.</p> <p>During a review of Resident 124's History and Physical (H&amp;P) dated 5/21/2025, the H&amp;P indicated Resident 124 had the capacity to understand and make decisions.</p> <p>During a review of Resident 124's Minimum Data Set (MDS - a resident assessment tool) dated 5/13/2025, the MDS indicated Resident 124 had the ability to understand others and had the ability to make himself understood.</p> <p>During a review of Resident 124's Order Summary Report dated 6/19/2025, indicated Resident 124 was prescribed Heparin Sodium (a medication to prevent blood clots and could cause bleeding) 5000 units (a unit of measurement) and Clopidogrel (a medication to prevent blood clots and could cause bleeding) 75 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount). The Order Summary Report indicated Resident 124 had a fistula.</p> <p>During a concurrent observation and interview on 6/17/2025 at 12:15 PM with Licensed Vocational Nurse 11 (LVN 11) in Resident 124's room, the resident did not have an emergency kit at the resident's bedside. LVN 11 stated Resident 124 did not have an emergency kit at the bedside and would be at risk for bleeding without the emergency kit.</p> <p>b. During a review of Resident 491's admission Record, the admission Record indicated Resident 491 was admitted on [DATE] with diagnoses that included diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), ESRD (End Stage Renal Disease-irreversible kidney failure, and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 491's Care Plan Report dated 6/13/2025, the Care Plan Report indicated the resident needed hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) related to renal (kidney) failure. The Care Plan Report indicated the nursing interventions would be to monitor Resident 491 for bleeding</p> <p>During a review of Resident 491's Order Summary Report dated 6/19/2025 indicated Resident 491 had a renal shunt (also known as a dialysis fistula).</p> <p>During a concurrent observation and interview on 6/16/2025 at 1:16 PM with LVN 12 in Resident 491's room, the resident's emergency kit was observed to be missing and not at the resident's bedside. LVN 491 stated the emergency kit was missing and the facility would need the emergency kit case Resident 491 bled.</p> <p>During an interview on 6/17/2025 at 12:19 PM with the Director of Nursing (DON), the DON stated Resident 124 and Resident 491 would be at risk for bleeding continuously from their dialysis fistula if they did not have an emergency kit at the bedside to help stop the bleeding.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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:</p> <ol style="list-style-type: none"> <li>1. Ensure nursing staff would document medication administrations properly for two of four sampled residents (Resident 89 and Resident 86).</li> </ol> <p>This failure had the potential for medication error and/or drug diversion (refers to the illegal and unauthorized transfer of legally obtained drugs from their intended use to an unintended use or recipient).</p> <ol style="list-style-type: none"> <li>2. Ensure home medications brought in by one of one discharged sampled resident (Resident 900) were returned to the resident.</li> </ol> <p>This failure had the potential for drug diversion (involving the transfer of a legally-prescribed controlled substance from the individual for whom it was prescribed to another person) and/or misuse of personal property.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a medication administration (med pass) observation on 6/18/2025 at 8:27 AM Licensed Vocational Nurse4 (LVN 4) did not administer Resident 89's medication order (dated 7/16/2024) for diclofenac sodium (a medication used to relieve pain and inflammation in certain joints) external gel 1 %, with an instruction to apply to the right shoulder two times a day for pain management. (Refer to 759, F658)</li> </ol> <p>During an interview on 6/18/2025 at 1:30 PM LVN 4 stated Resident 89 had not needed diclofenac gel for at least two weeks.</p> <p>During a review of the Resident 89's Medication Administration Record (MAR) of June 2025, the MAR indicated there were 35 of 35 administrations of the diclofenac gel. There was no indication the gel was not administered.</p> <p>During an interview on 6/18/2025 at 1:38 PM, the Director of Nursing (DON) reviewed Resident 89's MAR and stated nurses (in general) should circle their initials and document in the back of the MAR if they did not administer the medication. The DON stated the back of the MAR was empty.</p> <p>During a concurrent interview on 6/18/2025 at 1:38 PM LVN 4 stated she (LVN4) forgot to document diclofenac as not given or refused.</p> <p>During a review of Resident 86's Dilaudid (hydromorphone, a potent narcotic and controlled substance to treat pain) on 6/18/2025 at 2:38 PM, Resident 86's Dilaudid count sheet (inventory accountability sheet) indicated the last dose taken out was on 6/10/2025 at 8 PM.</p> <p>During a concurrent interview on 6/18/2025 at 2:38 PM LVN 2 reviewed Resident 86's MAR and stated there was no administration documentation of Resident 86's Dilaudid on 6/10/2025.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/18/2025 at 3 PM, the DON stated the nurses (unidentified) forgot to document the administration of Dilaudid on Resident 86's MAR.</p> <p>During a review of the facility policy and procedures, Administering Medications (dated December 2024), the policy indicated . The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones .</p> <p>2.During an observation and interview on 6/17/2025 at 12:45 PM at the Director of Nursing's (DON) office, the DON opened a locked drawer and stated the drawer stored narcotics (pain relief medication) to be disposed or destructed with the facility's pharmacist. Inside the drawer, there were twelve (12) counts of lorazepam (generic for Ativan, a controlled substance to treat anxiety [nervousness]) 2 milligrams (mg, unit to measure mass) per (/) milliliters (ml, unit to measure volume) oral syringes. The DON stated a nurse (unidentified) brought those syringes to her on 6/17/2025 for disposition (is the process of returning and/or destroying unused medications). The DON reviewed the labels on the aforementioned oral syringes and stated those were for a resident (Resident 900) who had been discharged to a hospital on 1/21/2025. The DON stated those aforementioned oral syringes were home medications brought into the facility by the resident. The DON reviewed the discharged resident's medication list and stated lorazepam oral syringes were not part of the resident's discharge medications. The DON stated she was not sure why the syringes were still at the facility.</p> <p>During an interview on 6/17/2025 at 12:49 PM, the DON stated personal medication were considered resident's personal properties and should be returned to the resident or family member at the time of discharge.</p> <p>During an interview on 6/17/2025 at 1:02 PM, the DON stated the facility did not have a policy on how to handle medications that residents brought in from home; however, there was a policy on personal property.</p> <p>During a review of the facility's policy and procedures, Personal Property (dated [DATE]), the policy did not denote what to do with personal property when resident was discharged .</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 45) did not receive medication without a physician order and/or without adequate indication of use.</p> <p>This failure had the potential for medication error and delay in proper treatment that may or may not affect Resident 45's condition negatively.</p> <p>(Cross Reference 759)</p> <p>Findings:</p> <p>During an observation on 6/18/2025 at 8:49 AM, Licensed Vocational Nurse 3 (LVN 3) applied the diclofenac sodium (a medication used to relieve pain and inflammation in certain joints) external gel 1 %, to Resident 45's both knees. (Refer to F-759)</p> <p>During an interview on 6/18/2025 at 10:38 AM, LVN 3 reviewed Resident 45's Medication Administration Record (MAR) and the physician's order for diclofenac and LVN3 stated the order was to apply to resident's both hands, however, Resident 45 wanted the gel to be applied to the knees.</p> <p>During an interview on 6/18/2025 at 3:40 PM, the Director of Nursing (DON) stated the applications of diclofenac gel to the Resident 45's knees were administered without a physician's order and evaluation.</p> <p>During a review of the facility's policy and procedures, Unnecessary Drugs (revised January 2025), the policy indicated . Unnecessary drugs include . used . without adequate indications for its use .</p> <p>During a review of the facility policy and procedures, Medication and Treatment Orders (dated December 2024), the policy indicated . Medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe .</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility failed to ensure its medication error rate was less than five (5) percents (%). Three medication errors out of 33 total opportunities yielded a medication error rate of 9.09%, in 3 of 4 sampled residents (Resident 114, Resident 89, and Resident 45) observed during medication administration (med pass).</p> <p>This failure of med pass error rate exceeded the 5 % threshold had the potential of adverse effects that may or may not affect Resident 114, Resident 89, and Resident 45's health condition.</p> <p>(Cross Reference F757 and F761)</p> <p>Findings:</p> <p>a. During a medication administration (med pass) observation on 6/17/2025 9:06 AM, outside Resident 114's room, the Licensed Vocational Nurse1 (LVN 1) prepared a total of three medications: vitamin C mg (also known as ascorbic acid, is a water-soluble vitamin essential for various bodily functions, including immune system support, wound healing, and collagen formation) 500 milligrams (mg, unit to measure mass), aspirin (a drug often used to prevent blood clots and heart attacks in low dose), and finasteride (generic for Propecia, used to treat hair loss and/or prostate condition).</p> <p>During a review of Resident 114's medication orders, the orders indicated there was an order not given. The order was doxazosin (generic for Cardura, used to treat high blood pressure and prostate condition) 2 mg one time a day at 9 AM started on 5/25/2025.</p> <p>During an interview on 6/17/2025 at 12:20 PM LVN 1 stated Resident 114's doxazosin 2 mg was not given because it was not in the medication cart earlier.</p> <p>During an observation and concurrent interview on 6/17/2025 at 12:30 PM with the Director of Nursing (DON) and LVN 1 at Station A medication cart 3, LVN 1 found Resident 114's doxazosin 2 mg bubble pack (a card that packages doses of medication within small, clear plastic bubbles or blisters) in a drawer that kept evening medications. (see also F761)</p> <p>During a medication administration (med pass) observation on 6/18/2025 at 8:27 AM the Licensed Vocational Nurse (LVN 4) prepared eight oral medications for Resident 89.</p> <p>b. During a review of Resident 89's medication orders, the orders indicated there was an order dated 7/16/2024 for diclofenac sodium (a medication used to relieve pain and inflammation in certain joints) external gel 1 %, with an instruction to apply to the right shoulder two times a day for pain management, which was not administered.</p> <p>During an interview on 6/18/2025 at 11:11 AM, when asked about Resident 89's diclofenac sodium external gel that was due at 9 AM but was not seen during the med pass earlier, LVN 4 stated Resident 89 did not ask for it . However, the order did not mention as needed.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. During a med pass observation on 6/18/2025 at 8:49 AM, LVN 3 prepared 15 medications for Resident 45. One of the 15 medications was diclofenac external gel 1 %. LVN 3 applied the gel to Resident 45's knees, both left and right.</p> <p>During a review of Resident 45's medication orders, the order for diclofenac sodium external gel 1% (dated 8/24/2024) indicated apply to both [NAME] [hands] topically two times a day for pain management.</p> <p>During an interview on 6/18/2025 at 10:38 AM, LVN 3 reviewed Resident 45's MAR for diclofenac and stated the order was to apply to both hands, however, on the morning of 6/18/2025 Resident 45 wanted the gel to apply to the knees. (Refer to 757)</p> <p>During a review of the facility's policy and procedures, Administering Medications (dated December 2024), the policy indicated Medications are administered in a safe and timely manner, and as prescribed . Medications are administered in accordance with prescriber orders, including any required time frame . The individual administering the medication checks the label THREE (3) times to verify the right . dosage, right time . before giving the medication .</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the label on a bubble pack (a card that packages doses of medication within small, clear plastic bubbles or blisters) matched the physician's order for one of four sampled residents (Resident 114).</p> <p>This failure had the potential of medication error that may or may not affect resident's condition.</p> <p>(Cross Reference F759)</p> <p>Findings:</p> <p>During an observation and concurrent interview on 6/17/2025 at 12:30 PM at the Station A medication cart 3, the Licensed Vocational Nurse (LVN 1) found Resident 114's doxazosin (generic for Cardura, used to treat high blood pressure and prostate condition) 2 milligrams (mg, unit to measure mass) bubble pack in a drawer that stored evening medications. LVN 1 pointed to the label on the bubble pack and stated the label indicated take one tablet by mouth at bedtime. During a concurrent review of the medication administration record (MAR) of Resident 114's doxazosin, LVN 1 stated the scheduled time was at 9 AM.</p> <p>During a review of Resident 114's medication orders, the orders indicated there was an order not given. The order was doxazosin (generic for Cardura, used to treat high blood pressure and prostate condition) 2 mg one time a day at 9 AM started on 5/25/2025.</p> <p>During an interview on 6/17/2025 at 12:36 PM, the Director of Nursing (DON) stated Resident 114's doxazosin was scheduled at 9 AM and the pharmacy should have notified the facility if there was any change made to the order.</p> <p>During a review of an email sent from the pharmacy to the DON, dated 6/17/2025 at 9:32 PM, the email indicated Resident [114] had an order for doxazosin 2 mg daily at 9 am on 5/25/25. The order from the pharmacy was found to be doxazosin 2 mg at bedtime. It is the practice of the pharmacy to verify any changes to the prescription order with the prescriber, and to communicate this change to the facility (either with a phone call to a licensed nurse or via fax). Since the paper trail of this communication for this specific order is not found, the pharmacy staff will be inserviced to ensure this procedure is being followed and also to ensure to continue to document all communications with the facility regarding any changes of orders.</p> <p>During a review of the facility policy and procedures, Medication and Treatment Orders (dated December 2024), the policy indicated . Only authorized, licensed practitioners, . shall be allowed to write orders.</p>		

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  06/19/2025
NAME OF PROVIDER OR SUPPLIER  LA Brea Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  505 N. LA Brea Avenue Los Angeles, CA 90036	
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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>Based on observation, interview and record review, the facility failed to ensure two of 27 sampled residents (Resident 54 and Resident 39) were served food preferences listed on the lunch meal ticket (physician ordered diet with resident food preferences) when:</p> <ol style="list-style-type: none"> <li>1. Resident 54 who had lactose intolerance (lactose a sugar found in dairy products such as milk) was served chocolate flavored ice cream, despite lactose being listed as an intolerance on the resident's lunch meal ticket/tray care.</li> <li>2. Resident 39 was served pork despite cultural preferences for no pork or ham.</li> </ol> <p>These failures had the potential to result in decreased meal satisfaction, decrease caloric intake, Resident 54 and Resident 39 being upset and for Resident 54 to experience symptoms associated with lactose intolerance.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 54's Dietary Quarterly Progress Notes dated 3/11/25 and 6/13/25 indicated Resident 54's current diet was regular NAS (no added salt) and CCHO (diet for people to control blood sugar levels). The Dietary Quarterly Progress Notes indicated Resident 54 did not like milk or soy milk. The Dietary Quarterly Progress Notes indicated Resident 54 was ok with cheese. The Dietary Quarterly Progress Notes did not indicate Resident 54 dislike for sweets and chocolate.</li> </ol> <p>During a review of resident 54's meal ticket (lists residents' physician ordered diet with resident's food preferences and intolerances) for lunch dated 6/17/2025, the meal ticket indicated resident food intolerances included lactose intolerance and ok with cheese.</p> <p>During an observation in the kitchen on 6/17/2025 at 11:50AM, the dessert was prepared for service. Dietary Aide 5 (DA5) was looking at the resident's meal tickets on the tray and placing ice cream on resident's lunch tray.</p> <p>During an observation of lunch service in the kitchen on 6/17/2025 at 12 PM, Dietary Aide (DA5) served a chocolate flavored ice cream on Resident 54's lunch tray.</p> <p>During a concurrent observation and interview with the DS on 6/17/2025 at 12:05PM, DS stated residents' preferences are recorded on the meal ticket. The DS sated Staff would look at the meal tickets and serve beverages or ice cream according to the resident's preferences.</p> <p>During a dining observation on 6/17/2025 at 12:45PM, Resident 54's tray was on the bed side table. Resident 54 had not started eating lunch. There was one chocolate flavored ice cream on the tray.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview on 6/17/2025 at 12:45PM with Resident 54, Resident 54 was upset and stated the facility did not listen to his food preferences. Resident 54 stated the facility was aware that the resident had dairy intolerance. Resident 54 stated I can eat yogurt and cheese, but I don't like milk. Resident 54 stated I don't like sweets either and I will not eat the chocolate ice cream on the tray. Resident 54 stated most of the time the facility would make mistakes and would bring me sweets and desserts and I often return them back to the kitchen.</p> <p>During an observation of lunch service by the nurses' station on 6/18/2025 at 12:30 PM, one meal cart was delivered. Staff started distributing the trays before checking for diet accuracy.</p> <p>During an observation of lunch service by the nurse's station on 6/18/2025 at 12:35 Licensed Vocational Nurse10 (LVN10) arrived and started checking rest of the trays.</p> <p>During an interview on 6/18/2025 at 12:35 with LVN10, LVN10 stated the trays were checked for diet accuracy. LVN10 stated arrived late today because was busy with resident. LVN10 stated the Director of Staff Development (DSD) would also assist in checking the trays when a nurse was busy.</p> <p>During an interview with DSD on 6/18/2025 at 12:45PM, the DSD stated nurses would check the diets for accuracy before delivering to the resident. The DSD stated did not see if LVN10 checked the trays on the first meal cart before it was distributed. The DSD did not know why Resident 54 received the chocolate flavored ice-cream despite lactose intolerance was listed on the meal ticket.</p> <p>During an interview with DA5 on 6/18/2025 at 1 PM, DA5 stated on 6/17/2025 the dessert was ice cream. DA5 stated lactose intolerance was someone who could not have dairy products like milk, cheese yogurt and ice cream. DA5 stated there were some residents who did not like dairy and the facility offered them non dairy ice cream or sherbert. DA5 stated he made a mistake serving chocolate ice cream on the Resident's 54 tray.</p> <p>During an interview with Registered Dietitian (RD) on 6/18/2025 at 1:30PM, the RD stated any person with intolerance to dairy products could have upset stomach, bloating, and diarrhea when eating ice-cream.</p> <p>During a review of facility's policy titled Food and Nutrition Services (Revised 12/2024) indicated, Each resident is provided with .well balanced diet .taking into consideration the preferences of each resident, Reasonable efforts will be made to accommodate resident choices and preferences, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident .If an incorrect meal is provided toa resident .nursing staff will report it to the food service manager.</p> <p>2. During a review of Resident 39's admission Record, the admission Record indicated the facility admitted the resident on 6/11/2025 with diagnoses that include type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), iron deficiency anemia (a condition where the body does not have enough healthy red blood cells), vitamin D deficiency (the body does not have enough vitamin D to function properly), gastro-esophageal reflux disease (stomach acid frequently flows back into the esophagus, causing heartburn and other issues), and acute kidney failure (a sudden and rapid loss of kidney function).</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 39's Nutritional Screening, dated 6/12/2025, the Nutritional Screening indicated Resident 39's ethnic, religious, cultural preferences were no pork or ham.</p> <p>During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool) dated 6/13/2025, the MDS indicated the resident had an intact cognitive function (impairment in the ability to think, understand and reason).</p> <p>During a review of Resident 39's Order Summary Report, dated 6/18/2025, the Order Summary Report indicated, Resident 39 diet: NAS (No-Added Salt), CCHO (Consistent or Controlled Carbohydrate) diet, regular texture, regulars consistency three times a day.</p> <p>During a review of Resident 39's CNA/STNA Function Abilities Flow Sheet, undated, the CNA/STNA Function Abilities Flow Sheet indicated Resident 39's meal percentage consumed 100% of breakfast since admission.</p> <p>During a review of Resident 39's Dietary Slip, dated 6/19/2025, the Dietary Slip indicated that Resident 39 had dislikes to ham and pork for breakfast, lunch, and dinner.</p> <p>During a review of Resident 39's Nursing Care Plan, dated 6/13/2025, the Nursing Care Plan indicated Resident 39 is refusing to eat - did not like the food served. Interventions include: Dietary supervisor will follow up to ensure his food preferences are strictly noted on his meal ticket to avoid unnecessary mistakes. Dietary supervisor will re-educate his staff on adherence of food preferences &amp; restrictions.</p> <p>During an interview on 6/16/2025 at 12:38 PM with Resident 39, Resident 39 stated he needed to stay on his diet and eat healthy foods like vegetables, salad, and a little bit of fruit and toast.</p> <p>During an interview on 6/16/2025 at 12:44 PM with the Dietary Supervisor (DS) in Resident 39's bedroom, Resident 39 stated he was Muslim and did not want to be served pork. Resident 39 stated he wanted chicken or fish. The DS stated his apologies for his new staff's mistake when the resident was served pork.</p> <p>During an interview on 6/18/2025 at 1:14 PM with Resident 39, Resident 39 stated there was only one incident that he was served a sausage for breakfast but unsure of exactly when.</p> <p>During an interview on 6/18/2025 at 3:01 PM with the Registered Dietitian (RD), the RD stated she spoke with Resident 39 in regards to his diet. RD stated she spoke about current diet plans, educated on what it means to have carbs but spread out and sugar free desert. The RD stated Resident 39 verbalized understanding but had his own ideas on what foods were good and bad for diabetes. The DS stated Resident 39 mentioned having toast for breakfast and being okay with breakfast.</p> <p>During an interview on 6/19/2025 at 1:50 PM with the DS, the DS stated Resident 39 claimed to be Muslim and requested chicken and fish. The DS stated the facility was doing their best to accommodate the resident's preferences.</p> <p>During an interview on 6/19/2025 at 2:28 PM with the Director of Nursing (DON), the DON stated that it was important the diet given to the resident was not contraindicated to their preferences so that they could enjoy their meal according to the prescribed diet from the Medical Doctor (MD).</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Menus dated December 2024, the P&amp;P indicated, Menu items and available snacks reflect the religious, cultural and ethnic preferences of the residents, whenever reasonable.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review the facility failed to ensure safe and sanitary food storage practices in the kitchen for 124 of 135 residents who received food from the facility and including residents who had food stored in the resident refrigerator when:</p> <ol style="list-style-type: none"> <li>One opened container of cottage cheese was observed unlabeled in the refrigerator. A plastic bag that contained a staff member's (unidentified) lunch was observed in the refrigerator.</li> <li>The temperature of TCS foods (Time/Temperature control for safety food) checked was above 41 degrees Fahrenheit (F). TCS foods are foods that can support bacterial growth than can result in food borne illness unless stored, prepared and served safely. The temperature of a previously cooked rice from 6/16/2025 stored in the walk-in refrigerator checked using the facility thermometer was 45.5 degrees Fahrenheit (F). There was one tray of previously cooked breakfast sausage stored on the same shelf and next to raw chicken and beef thawing. This had the potential to cross contaminate food and result in food borne illness in 124 out 135 residents who received food from the kitchen.</li> <li>The floor and shelving in the dry storage area were dirty, there was one plate of cookies covered with plastic wrap with expiration date of 6/3/25 expired stored on the shelf in the dry storage. The bottles and containers of cooking sauces was covered with the sauce and was sticky to touch. One toaster oven was not clean and covered with breadcrumbs.</li> <li>Cook1 did not follow cleaning and sanitizing procedure after preparing raw chicken in the food preparation sink and then one Dietary Aide DA2 used the same sink to wash vegetables.</li> <li>One Dietary Aide (DA4) working in the dish machine area did not wash hands and change gloves when removing the clean and sanitized dishes from the dish machine.</li> <li>Food brought to residents (unidentified) from outside of the facility, were stored in the resident's food refrigerator with no date and not monitored for the expiration date. The refrigerator temperature log was missing for the month of June. There were seven plastic bags with food inside not dated and one unopen package of cheese that was expired stored in the refrigerator.</li> <li>One unlabeled plastic bag with five pre-packaged meals, four gelatin snack packs, and two sandwich bags filled with pastries were observed unlabeled in the dry storage room.</li> </ol> <p>These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness in 124 out of 135 residents who received food from the facility and including residents who had food stored in the resident refrigerator.</p> <p>Findings:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. During a concurrent observation and interview on 6/16/2025 at 8:01 AM, with the Dietary Supervisor (DS), in the facility kitchen, the refrigerator was observed. In the refrigerator one opened container of cottage cheese without an open date label and a knotted plastic bag dated 6/16/2025 were observed. The DS stated the open container of cottage cheese was unlabeled. The DS stated the plastic bag dated 6/16/2025 was a dietary staff's (unidentified) lunch. The DS stated that all food containers and items should be dated and labeled. The DS stated food containers that were opened should be labeled with the open date so dietary staff know if the food quality was still good. The DS stated dietary staff should not store their personal lunch in the kitchen refrigerator.</p> <p>2. During an observation in the kitchen on 6/17/2025 at 9:15AM One medium deep pan of cooked rice dated 6/16/2025 was noted in the walk-in refrigerator. The temperature of the rice was checked with facility thermometer. The temperature of the rice in the middle of the pan registered at 45.5 degrees F.</p> <p>During a concurrent observation and interview on 6/17/2025 at 9:15AM with the Dietary Supervisor (DS), the DS stated cold food should be held at 41 degrees or lower and the rice was not held at the right temperatures and would be discarded. The DS stated this was a mistake because the facility did not store left over food.</p> <p>During a review of facilities' policy titled Procedure for Refrigerated Storage (dated 2023), the policy indicated Refrigerator 41F or lower .to keep food at a specific temperature, the air temperature in the refrigerator usually must be about 2 degrees F lower. for example, to hold chicken at 41F, the air temperature must be 39F</p> <p>During a review of the 2022 U.S. Food and Drug Administration Food Code 3-501.16 titled Time/Temperature control for safety food, hot and cold holding indicated, except during preparation, cooking or cooling, time/temperature control for safety food shall be maintained at 135degrees F or above, and at 41 degrees F or below.</p> <p>During an observation in the walk-in refrigerator on 6/17/2025 at 9:15AM there was one tray of previously cooked breakfast sausage stored on the same shelf and next to raw chicken and beef that were thawing. The tray of cooked sausage had a date of 6/17/2025.</p> <p>During a concurrent observation and interview on 6/17/2025 at 9:15AM with the DS, the DS stated the sausages were left over from the morning breakfast on 6/17/2025. The DS stated the sausages were ready to eat and should not be stored next to raw beef and chicken that are thawing. The DS stated there was a potential for cross contamination of raw chicken or beef drippings on the cooked product.</p> <p>During a review of the 2022 U.S. Food and Drug Administration Food Code 3-301.11 titled Packaged and unpackaged Food-Separation, segregation indicated, (A)Food shall be protected from cross contamination by: (1) Separating raw animal foods during storage, preparation, holding and display: (b) Cooked Ready-To-Eat Food.</p> <p>3. During an observation in the dry storage area on 6/17/2025 at 9:20AM, the floor behind the shelf was dirty with food particles. Bags of macaroni stored in a large container and there was food debris and dust inside it. There was one plate of cookies wrapped with plastic bag and dated 6/3/2025 exceeding storage period for the cookies and had food debris inside.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During the same observation on 6/17/2025 at 9:20AM, there were bottles of soy sauce, teriyaki sauce, and tother seasoning sauces for cooking stored on the bottom shelf. The seasoning and sauce bottles were covered with brown color sticky substance and drippings.</p> <p>During a concurrent observation and interview with the Dietary Supervisor (DS) on 6/17/2025 at 9:20AM, the DS stated staff sweep everyday but did not do a good job because there were food debris on the floor under the shelves and in the corners. The DS stated there were some flour and sugar like dust on top of the lids and it could attract pests to the dry food storage area.</p> <p>During the same observation and interview on 6/17/2025 at 9:20AM the DS stated any leftover and open food was stored for three days. The DS discarded the plate of cookies that was in the dry storage area and asked staff to wipe the bottles of sauces and condiments. The DS stated sticky bottles could attract flies.</p> <p>During an observation in the kitchen on 6/17/2025 at 11 AM, the countertop bread toaster (conveyor toaster oven for bread) the conveyor tray was covered with crumbs. The crumbs were stuck on the stainless-steel rotating (conveyor) wire and tray, inside the toaster oven and outside under the toaster oven and on the counter.</p> <p>During an observation and interview with Dietary Aide (DA1) on 6/17/2025 at 11 AM, DA1 stated the toaster oven was for toasting bread and breadcrumbs were stuck on the racks and inside the oven. DA1 stated we clean it but can't remember last time it was cleaned. DA1 stated the staff should clean it to prevent attracting pests.</p> <p>During an observation and interview with the DS on 6/17/2025 at 11 AM, the DS stated there was a lot of breadcrumbs and the breadcrumbs was not from today, (6/17/2025) alone. The DS stated he did not know when the inside of the oven was cleaned.</p> <p>During a review of facility cleaning schedule and check list, the schedule indicated a weekly cleaning of the storeroom. The schedule did not indicate cleaning the conveyor toaster for bread.</p> <p>During a review of facility's policy titled Storage of Food and Supplies (dated 2023) the policy indicated, The storeroom should be .clean at all times.; routine cleaning and pest control procedures should be developed and followed; liquid foods such as syrup, oil, vinegar, Worcestershire sauce .which have been opened will be tightly closed, labeled and dated.</p> <p>During a review of facility's policy titled Sanitation (dated 2023) the policy indicated, All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam .</p> <p>During a review of the 2002 U.S. Food and Drug Administration Food Code, code 3-304.11 titled Food Contact with Equipment and Utensils code indicated, Food shall only contact surfaces of: (A) Equipment and utensils that are cleaned and sanitized .Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. During an observation in the food preparation area on 6/17/2025 at 9:10AM, observed [NAME] (cook1) washing the raw chicken inside the two-compartment food preparation sink. Cook1 then removed the chicken and placed it inside a large round pan and began to add seasonings to the chicken and proceeded to cooking process. Cook1 did not wash and sanitize the sink after finishing with the raw chicken preparation.</p> <p>During a food preparation observation on 6/17/2025 at 9:30AM, observed DA2 holding the lettuce and cucumber and rinsing them under running water in the same sink that was used to wash the chicken. DA2 then started chopping the lettuce on a cutting board next to the sink.</p> <p>During the same observation on 6/17/2025 at 9:30AM observed pieces of the raw chicken inside the sink and near the faucet.</p> <p>During an observation and interview with DA2 on 6/17/2025 at 9:30AM, DA2 stated once the lettuce and cucumber was chopped then it would be thoroughly washed and drained in the sink. DA2 stated the sink was clean but still the lettuce and cucumber would not be placed directly inside the sink. DA2 stated the chopped lettuce, and cucumber would be washed inside a pan in the sink. DA2 stated when everyone was finished with their work with the sink, it was expected to wash and sanitize the sink using detergent for washing then the sanitizer solution to sanitize the sink. DA2 stated she did not know the sink was used for the washing of raw chicken and not cleaned after.</p> <p>During an interview with cook1 and the DS on 6/17/2025 at 9:45AM, Cook1 stated he did not wash and sanitize the sink after washing and marinating the raw chicken. Cook1 stated we always wash and sanitize sink when working with raw meat. Cook1 stated he forgot and made a mistake. Cook1 stated this could cross contaminate the vegetables that was going to be used for salad.</p> <p>During the same interview on 6/17/2025 at 9:45AM the DS instructed to clean the sink and discard ready to eat vegetables that were rinsed in the sink.</p> <p>During a review of facility's policy titled Sanitation (dated 2023) the policy indicated, Each employee shall know how to operate and clean all equipment in his specific work area.</p> <p>During a review of facility's cleaning procedure titled Shelves, counters and other surfaces including sinks (handwashing, Food Preparation.) (dated 2023) the policy indicated remove any large debris and wash surface with warm detergent solution .rinse with clear water .spray with a sanitizer.</p> <p>During a review of the job description for cooks, it indicated demonstrated knowledge of how to clean and sanitize equipment and counter tops</p> <p>5. During an observation in the dishwashing area on 6/17/2025 at 10:15AM, Dietary Aide (DA4) was rinsing soiled dishes and loading the dirty dishes in the dish machine. DA4 had gloves on hands, DA4 rinsed hands with gloves in the manual ware washing sink dried the gloved hands with a kitchen cloth stored on the counter and proceeded to remove the clean and sanitized dishes from the dish machine without washing hands and replacing gloves. DA4 repeated the same process of loading dirty dishes, rinsing gloved hands then picking up clean dishes twice during the observation.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview with DA4, DA1 and DS on 6/17/2025 at 10:30AM, DA4 stated he was rushing to finish the work, and he did not remove gloves, wash hands and replace gloves. DA4 stated usually there were two people working in the dish machine area to help remove the clean dishes but on 6/17/2025 the dishes were heavily soiled with sticky food item and the other staff was busy with soaking and rinsing dishes and then send the dishes to be loaded in the dishwashing machine. DA4 stated not washing hands can contaminate clean and sanitized dishes. DS stated all dishes would be rewashed and sanitized.</p> <p>During a review of facility's policy titled, Glove Use Policy (dated 2023) indicated, When gloves need to be changed: 2. Before beginning a different task</p> <p>During a review of facility's policy titled Sanitation (dated 2023) the policy indicated, A minimum of two employees will be used when dishes are machine washed. One will handle the soiled area, and one will handle the clean side. If an employee does need to go from soiled end to clean end, a strict hand washing routine must be followed .Note that hands must be thoroughly washed and clean before handling lean dishes and utensils. Cup.</p> <p>6. During an observation in the resident refrigerator located in the facility's Utility Room on the 3rd floor on 6/18/2025 at 9 AM, the refrigerator temperature log for the month of June was missing.</p> <p>During a concurrent observation and interview on 6/18/2025 at 9 AM with the nurse supervisor (RN2), RN2 stated she did not know what happened to the temperature monitoring log for the month of June. RN2 stated the residents' family (in general) would bring food, or the residents (in general) would order food and leftovers are stored in the resident refrigerator, labeled and dated for the time it was brought in.</p> <p>During the same observation on 6/18/2025 at 9 AM in the resident refrigerator there were seven plastic bags with resident leftover food stored with resident room number and no date. There was one unopened package of cheese with no label and manufactures expiration date of 6/7/2025 expired and stored in the refrigerator. The refrigerator was dirty with food debris and there were sticky stains. The freezer was empty but was covered in ice.</p> <p>During a concurrent interview with the Director of Staff Development (DSD) on 6/18/2025 at 9:30AM, the DSD stated family hands over the food to the nursing staff. The DSD stated any leftovers were labeled and dated then stored in the refrigerator for 72 hours. The DSD stated housekeeping was responsible to check the temperature of the resident refrigerator and discard any food that was beyond 72 hours. The DSD stated dates were important because food expires and needed to know when to discard. The DSD stated temperature monitoring was also important to make sure food was kept at safe temperature. The DSD stated everything would be discarded because there was no temperature log since 5/31/2025, no dates, and the facility did not know when the food was brought in.</p> <p>During an interview with Maintenance and Housekeeping Director (MAD1) on 6/18/2025 at 10 AM, MAD1 stated housekeeping and maintenance staff were not assigned to check the resident food refrigerator temperatures. MAD1 stated housekeeping did not monitor temperature or discarded the resident food.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility's policy titled, Foods Brought by Family/Visitors (revised 12/2024) indicated, Food brought by family/visitors that is left with the resident to consume later will be labeled and stored .Perishable foods must be stored in resealable containers with tightly fitting lids in a refrigerator container will be labeled with residents name, the item and the use by date. The nursing staff will discard perishable foods on or before the Use By date.</p> <p>7. During a concurrent observation and interview on 6/16/2025 at 8:10 AM, with the DS, in the facility kitchen, the dry storage room was observed. In the dry storage room an unlabeled plastic bag with five pre-packaged meals, four gelatin snack packs, and two sandwich bags filled with pastries were all observed unlabeled. The DS stated the plastic bag contained food that was brought in by family for one of the facility residents (unidentified). The DS stated the food in the plastic bag were all kosher (food and beverages that are permissible for consumption according to Jewish dietary laws). The DS stated the food in the plastic bag was not labeled for the resident or labeled as kosher. The DS stated all food in the kitchen should be labeled, especially if they are kosher or for a certain resident. The DS stated food stored in the kitchen should be labeled and dated to prevent the residents from foodborne illness.</p> <p>During an interview on 6/19/2025 at 11:30 AM with the Director of Nursing (DON), the DON stated opened food in the kitchen should be dated and labeled with the open date. The DON stated food that was brought into the facility by family (in general) should be dated and labeled for the resident. The DON stated that facility staff had an employee refrigerator in the employee lounge. The DON stated staff lunch should not be stored in the kitchen. The DON stated staff lunch should be put and stored in the employee lounge refrigerator. The DON stated the improper storage and labeling of food in the kitchen could potentially lead to infection control issues and foodborne illness amongst the facility residents.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Procedure for Refrigerated Storage dated 2023, the P&amp;P indicated Food items should be arranged so that older items will be used first. Dating the packages or containers will facilitate this practice .Leftovers will be covered, labeled, and dated .Individual packages of refrigerated or frozen food taken from the original packing box need to be labeled and dated.</p> <p>During a review of the facility's P&amp;P titled Storage of Food and Supplies dated 2023, the P&amp;P indicated Food and supplies will be stored properly and in a safe manner.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Foods Brought by Family/Visitors dated 12/2024, the P&amp;P indicated Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. Non-perishable foods will be stored in re-sealable containers with tight-fitting lids. Intact fresh fruit may be stored without a lid. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date.</p>		

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NAME OF PROVIDER OR SUPPLIER  LA Brea Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  505 N. LA Brea Avenue Los Angeles, CA 90036	
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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> During a review of Resident 101's admission Record, the admission Record indicated the facility admitted Resident 101 on 11/5/2024 with diagnoses that included seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), Parkinson ' s Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), HIV (Human Immunodeficiency Virus Disease (a virus that attacks the body's immune system), weakness, and anxiety disorder (mental health conditions that cause fear, dread and other symptoms)</p> <p>During a review of Resident 101's History and Physical (H&amp;P) dated 11/7/2024, the H&amp;P indicated Resident 101 had lack of coordination and needed safety precautions.</p> <p>During a review of Resident 101's MDS dated [DATE], the MDS indicated Resident 101 sometimes understood others and sometimes had the ability to understand others.</p> <p>During a review of Resident 101's general progress note dated 6/19/2025 at 7:42 AM, indicated Licensed Vocational Nurse 5 (LVN 5) instructed Resident 101 to use her call light for assistance.</p> <p>During a concurrent observation and interview on 3/16/2025 at 1:16 PM with CNA 3, Resident 101 was observed asleep in her wheelchair next to her bed with the call light positioned on the bed out of the reach of Resident 101. CNA 3 stated the call light should be within Resident 101's reach so she could call for assistance if needed. CNA 3 repositioned the call light next to Resident 101 within the resident's reach.</p> <p>During a review of the facility's policy and procedure (P&amp;P) dated 12/2024, indicated the purpose of this procedure is to ensure timely responses to the resident's requests and needs. The P&amp;P indicated when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. The P&amp;P indicated some residents may not be able to use their call light. Be sure you check these residents frequently.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the call lights (a device used by a patient to signal his or her need for assistance) were within reach for two of 27 sampled residents (Residents 69 and Resident 101).</p> <p>This failure had the potential not to meet the needs of Resident 69 and Resident 101.</p> <p>Findings:</p> <p>During a review of Resident 69's admission Record, the admission Record indicated the facility originally admitted Resident 69 on 2/10/2023 and readmitted the resident on 4/8/2025 with diagnoses of end stage renal disease (a condition where the kidneys are so damaged that they can no longer filter waste and excess fluid from the blood effectively), need for assistance with personal care, history of falling, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle wasting and atrophy (the gradual wasting away or shrinking of an organ, tissue, or muscle), encephalopathy (a condition where the brain does not function properly) and dementia (a progressive state of decline in mental abilities).</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 4/29/2025, the MDS indicated Resident 69 sometimes was able to make herself understood and sometimes was able to understand others. The MDS indicated Resident 69's vision was highly impaired. The MDS indicated Resident 69 was always incontinent of urine and stool (inability to control when you urinate or have a bowel movement).</p> <p>During a concurrent observation and interview on 6/18/2025 at 12:03 PM with Licensed Vocational Nurse 2 (LVN2), Resident 69 was observed sleeping in her bed with her call light dangling off of the bed, not within her reach. LVN2 stated Resident 69 was blind and the call light was out of the resident's reach.</p> <p>During an interview on 6/18/2025 at 12:08 PM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 69's call light could have been pinned to the resident's gown so Resident 69 could reach it.</p> <p>During an interview on 6/18/2025 at 12:55 PM with the Director of Nursing (DON), the DON stated Resident 69 was blind in one eye. The DON stated Resident 69's call light should have been within her reach and could have been pinned to the resident's pillow on the side where the resident could see. The DON stated the call light should be within the resident's reach so the resident could call for assistance.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program (is the practice of managing and regulating undesirable organisms, commonly known as pests, that pose threats to human health) for 136 residents who resided in the facility to destroy and prevent cockroaches in the facility</p> <p>This failure resulted in the presence of one live cockroach in the utility room (a room where medical supply is stored and the location of the resident refrigerator for outside food and the unit ice machine) and placed 136 residents at risk of serious disease that can be transmitted through various routes (direct contact or inhalation) and by contaminating human food with germs (small living things/cells, especially one which cause diseases) that pests pick up from drains, garbage dumps and outside grounds.</p> <p>Findings:</p> <p>During a concurrent observation of the facility's utility room and interview with the Nurse Supervisor (RN2) on 6/18/2025, at 9 AM, one small brown cockroach was observed traveling from under the counter and went under the resident refrigerator for outside food. RN2 stated while observing the brown pest and stated that was cockroach and would contact the maintenance supervisor.</p> <p>During a concurrent observation of the facility's utility room and interview with the Director of Staff development (DSD) on 6/18/2025, at 9:30AM, one small brown cockroach was observed coming out from under the residents' (in geneneral) refrigerator, it was moving slowly and stopped moving then went under the residents' refrigerator. DSD stated the insect was a cockroach and stated would contact the maintenance supervisor and housekeeping to clean it up.</p> <p>During an interview with Maintenance and housekeeping Director (MAD1) on 6/18/2025 at 10 AM, MAD1 stated pest control services would go in once a month for services. MAD1 stated it was important to not have roaches to prevent cross contamination and for infection control for residents, so the residents would not get sick from it.</p> <p>During an interview with Infection prevention nurse (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria and viruses in a healthcare environment) on 6/18/2025 at 2:30PM, the IP nurse stated she (IP nurse) would make rounds every day in residents' rooms, offices and the utility room. The IP nurse stated she (IP nurse) had not observed any pests inside the facility and in resident rooms.</p> <p>During an interview with the MAD1 on 6/18/2025 at 3:00PM, MAD1 stated pest control services were every month. MAD1 stated pest control started the rounds outside of the facility parameters then would go inside the building to monitor the traps for pest activity, added and replaced the traps. MAD1 stated every month pest control would go in and check inside the facility in resident rooms, kitchen, offices and utility room.</p> <p>During a review of monthly pest control records from 2/17/2025 to 5/27/2025, it indicated for the month May on 5/27/2025 pest control only provided service outside of the building parameter and garage and did not come inside the building for monthly rooms inspection.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of pest control report dated 6/18/2025, it indicated one dead German cockroach (most common species of cockroach and its infestations most often seen in restaurant, food processing facilities, hotels and nursing homes.) was found in the utility room. The report also indicated Food debris found in employee lounge and the utility room. The report indicated food debris sitting over night or few days can be a condition that is conducive for pest.</p> <p>During a review of facility's policy titled Pest Control (revised 12/2024) indicated, Facility shall maintain an effective pest control program . an ongoing pest control program to ensure that the building is kept free of insects and rodents .maintenance series assist, when appropriate and necessary, in providing pest control services.</p>