

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056308	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER Heritage Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 21414 S. Vermont Avenue Torrance, CA 90502	

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 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144</p> <p>Based on observation, interview and record review, the facility failed to provide 80 square feet of space per resident in multiple resident bedrooms (29 and 30).</p> <p>This failure to provide adequate space had the possibility for negatively affecting the residents' quality of life, safety, and plan of care.</p> <p>Findings:</p> <p>During an observation on 10/22/2024 at 3:05 p.m. and interview with the Maintenance Supervisor (MS), MS completed the measurements of the following rooms:</p> <p>a. Resident room [ROOM NUMBER] and 30 measured 77.66 square feet (sq ft).</p> <p>MS stated the required room size for three of residents living in each of these room was 240 sq ft.</p> <p>During an observation on 10/22/2024 at 3:05 p.m., the residents' quality of life, care needs and safety were not adversely affected by the room size. Residents residing in rooms [ROOM NUMBERS] did not complain of the room space.</p> <p>During an interview with the Administrator on 10/22/2024 at 3:48 p.m., a room waiver for room [ROOM NUMBER] and room [ROOM NUMBER] has not been submitted by the facility for 2023 or 2024.</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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