STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056377	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rehabilitation Center on Pico	3233 W. Pico Boulevard Los Angeles, CA 90019

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that oral care was provided for one of three sampled residents (Resident 1) who required total assistance with personal hygiene according to care plan.This deficient practice result in that Resident 1 had white debris on his tongue requiring oral cleaning, placing Resident 1 at risk for developing fungal infection (any disease or condition you get from a fungus). During a review of Resident 1's admission records dated 6/10/2026, the admission record indicated Resident 1 was admitted on [DATE] with the diagnoses that included but not limit to: muscle weakness, dysphagia (a condition when someone can't swallow normally, which can make eating or drinking difficult), malnutrition (a condition when someone isn't eating enough of the right foods, causing their body to become weak or unhealthy), and syphilis (a disease caused by bacteria that usually spreads through sexual contact).During a review of Resident 1's history and physical (H&P) dated 5/30/2026, the H&P indicated Resident 1 had profound function declined and required assistance with activities of daily living.During a review of Resident 1's Minimum Date Set (MDS, a resident assessment tool) dated 6/4/2026, the MDS indicated Resident 1 had intact cognition (ability to think, remember and reason for daily decision making). Resident 1 was dependent on staff for oral hygiene.During a review of Resident 1's care plan date 6/9/2026, the care plan indicated Resident 1 required total assistance with personal hygiene.During an interview on 6/9/2026 at 11:31 AM, Certified Nursing Assistant (CNA) 1 stated Resident 1 was very depressed, frequently refused to eat, refused repositioning, and refused incontinent care/change the morning of 6/9/2026. CNA 1 further stated that she had reported to the Charge Nurse that Resident 1 was looking worse.During a current observation and interview on 6/9/2026 at 12:10 PM with the Treatment Nurse. Resident 1's mouth was assessed by the Treatment Nurse. The Treatment nurses verified that Resident 1's tongue had a white film present that required cleaning. The Treatment Nurse stated no staff had reported Resident 1 refusing care. The Treatment nurse further stated that any resident refusing care, nursing staff should continue offer, provide patient education and report.During an interview with the Director of Nursing (DON) on 6/9/2026 at 12:30 PM, the DON stated that the white film observed on Resident 1's tongue indicated a need for oral care. The DON explained that oral care is typically provided each shift, and failure to do so increases the Resident 1's risk of developing a fungal infection.During a review of the facility's policy and procedure (P&P) titled, ADL[activities of daily living] care provided for dependent residents, dated 1/2026, the P&P indicated oral care should be provide to residents to maintain of a health mouth.when resident refuse care, facility should document effects to inform and educated the resident.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure necessary care and services were provided for one of three sampled residents (Resident 1), who repeatedly refused food, medications, oral care, and hygiene services by failing to:Ensure a white film on the resident's tongue was assessed and treated.Ensure the resident's refusal of food, medications, oral care, and hygiene services were assessed, and care- planned with interventions.Ensure the resident's dentures were properly identified and accessible for use.During a record review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of toxic encephalopathy (disease of the brain that alters brain function or structure), pulmonary cryptococcosis (a fungal infection of the lungs with symptoms ranging from mild cough and chest pain to respiratory failure), Atrial fibrillation (A-fib: an irregular and often very rapid heart rhythm, can lead to blood clots in the heart).During a record review of Resident 1's Minimum Data Set (MDS- resident assessment tool) dated 6/4/2026, the MDS indicated Resident 1 had intact cognition (ability to think, remember and reason for daily decision making). Resident 1 was dependent on staff for eating, sitting up, lying to sitting on side of bed, chair/bed to chair transfer, repositioning, oral hygiene, toileting, shower bathe, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.During a review of Resident 1's Medication Administration Record (MAR), dated June 2026, the MAR indicated Resident 1 refused prescribed HIV (HIV- is a virus that attacks the body's immune system) and A-fib medications for 8 consecutive days starting 6/2/2026 through 6/9/2026. The review of the electronic medical record (EMR) revealed that the physician was aware of the medication refusals; however, no new physician orders, assessments, care plan revisions, referrals, or additional interventions were identified related to the ongoing refusals.During a review of Resident 1's Care Plan, the Care Plan did not indicate interventions to ensure dentures were properly stored, labeled, and made accessible to the resident to promote oral intake and oral hygiene.During a concurrent observation and interview on 6/9/2026 at 10:57 AM with Resident 1, in Resident 1's room, Resident 1 was observed lying in bed in his room, A white film was observed on Resident 1's tongue. Resident 1 stated he was sad and felt lonely. Resident 1 stated he wished he had a family member nearby and reported having no appetite. Resident 1 stated he had not worn his dentures since admission and felt very weak. Resident 1 further stated it was too much effort to try and do things and had a lot of pain all over his body. Resident 1 kept grimacing, groaning, and guarding his body during the interview. During an interview on 6/9/2026 at 11:31 AM, with certified nursing assistant (CNA 1), CNA 1 stated Resident 1 was very depressed and frequently refused to eat, be repositioned, and be changed. CNA 1 also stated she reported to the Charge Nurse that Resident 1 was looking worse.During a concurrent observation and interview on 6/9/2026 at 12:10 PM with the Treatment Nurse in Resident 1's room, the Treatment Nurse stated staff had not reported Resident 1's refusals of care in the morning. The Treatment Nurse further verified Resident 1's tongue had a white film and acknowledged Resident 1 required oral care and mouth cleaning.During a concurrent observation and interview on 6/9/2026 at 1:06 PM with CNA 2 in Resident 1's room, CNA 2 stated she was unaware Resident 1 had dentures and verified that an unlabeled plastic bag was under Resident 1's bed, which contained Resident 1's dentures. Staff were unaware the dentures were in the bag and unable to confirm how long the dentures had remained there.During an interview on 6/9/2026 at 1:28 PM with the Director of Nursing (DON), the DON acknowledged Resident 1 had arrived in the facility in poor condition and despite the physician had been made aware of Resident 1's refusal of care, medications, and assessments, no new interventions were identified or implemented to address Resident 1's continued refusals.During an interview on 6/9/2026 at 1:30 PM with the Administrator, the Administrator stated if Resident 1 continued to refuse his HIV medications, as well as other vital medications, his (Resident 1's) condition could worsen.During a review of the facility policy and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedures (P&P) titled Behavioral Health Services dated 1/2026, indicated the facility staff shall offer behavioral health services which includes necessary care for person-centered care and reflects resident's goals, preferences and choices, and maximizes the resident's dignity, autonomy, privacy, socialization, independence, and safety. When a resident is identified by the interdisciplinary team as requiring more intensive behavioral health services the team will make reasonable attempts to provide for and /or change such services. The types of services needed are clearly identified and care planned with strategies to obtain such services, and based on the individual assessment.