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	03/19/2026

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 needs, and current treatments) to meet the needs for three of three sampled residents (Resident 21, Resident 37, and Resident 50) as evidenced by:Failing to create and implement a care plan for being Out on Pass ([NAME], taking a short, approved, temporary leave from the facility) for Resident 21 and Resident 50.Failing to create and implement a care plan for Resident 37's Low Air Loss Mattress (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries, localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device).These failures had the potential for Resident 21, Resident 37 and Resident 50 to receive inadequate care and/or supervision which could have affected the residents' quality of care and caused the residents' harm.Findings: 1. During a review of Resident 21's admission Record, the admission Record indicated the facility admitted the resident on 9/24/2025 with diagnoses that included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), dementia (a progressive state of decline in mental abilities), and hypertension (HTN, high blood pressure). During a review of Resident 21's Order Recap Report, the Order Recap Report indicated the resident had a physician order dated 10/5/2025 that indicated the resident could go out on pass for therapeutic services (services aimed at healing, fixing, or managing a health issue) for four hours with family. During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool) dated 12/26/2025, the MDS indicated the resident had moderately impaired cognition (a slight decline in thinking and memory). The MDS indicated Resident 21 was independent with eating, oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 21's Release of Responsibility for Leave of Absence form, the form indicated the resident went out on pass on 1/17/2026, 1/20/2026, 1/29/2026, 2/2/2026, 2/9/2026, 2/14/2026, 2/21/2026, 2/26/26, 3/2/2025, 3/3/2026, 3/8/2026, 3/9/2026, 3/10/2026, and 3/15/2026. During an observation on 3/16/2026 at 11:50 AM, Resident 21's room was observed with the resident's bed made and call light laying on top of the bed. Resident 21 was not observed in the room. During an interview on 3/16/2026 at 12:30 PM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 was (continued on next page)

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

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	056377	A. Building B. Wing	03/19/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not received instructions regarding medication administration during the time she was out on pass. During a review of Resident 50's admission Record, the admission Record indicated the facility initially admitted the resident on 4/5/2023, and readmitted on [DATE] with diagnoses that included necrotizing fasciitis(diabetes mellitus (a rare but extremely serious bacterial infection that spreads rapidly under the skin, destroying tissue, fat, and muscle), unspecified open wound left lower leg, muscle weakness(generalized),bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs)unspecified, and schizophrenia(a mental illness that is characterized by disturbances in thought), unspecified. During a review of Resident 50's Order Summary Report dated 9/3/2024, the Order Summary Report indicated the resident could go OOP, not to exceed 4 hours for therapeutic purposes. During a review of Resident 50's Minimum Data Set (MDS, a resident assessment tool) dated 12/16/2025, the MDS indicated the resident was cognitively intact (ability to think, understand, and reason). The MDS indicated Resident 50 was independent for upper body dressing, putting on and/or taking off footwear, and had the ability to walk at least 150 feet. During a review of Resident 50's Wandering/Elopement Risk Evaluation dated 3/16/2026, the Wandering/Elopement Risk Evaluation indicated the resident had the ability to walk or self-propel off the premise without assistance. During an observation on 3/16/2026 at 10:29AM, Resident 50 was not in his room. During an interview on 3/16/2026 at 1:07PM, with Resident 50 in his room, Resident 50 stated he would go out on pass from the facility every day. During a concurrent interview and record review on 3/17/2026 at 10:47 AM, with Licensed Vocational Nurse (LVN) 1, Resident 50's Order Summary Report and complete Care Plan Report were reviewed. LVN 1 confirmed there was no care plan for Resident 50 for being out on pass from the facility. LVN 1 stated Resident 50 should have had a care plan in place for safety and education that would have been included in the interventions, and to ensure the interventions were being met. LVN 1 stated if there was no care plan the facility would not have known that the residents' needs were being met. During a concurrent interview and record review on 3/17/2026 at 2:55 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Develop-Implement Comprehensive Care Plans dated 1/2026, was reviewed. The DON stated any licensed nurse or members of the interdisciplinary team (IDT, a collaborative group of diverse health care professionals from different fields who work together) could create a care plan. The DON stated a care plan was a way of communicating a plan of care for Resident 50 among staff by having interventions in place. The DON stated Resident 50 should have had a care plan for being out on pass from the facility as part of his psychosocial (the interaction between a person's emotional/mental health and their social environment) needs being met. The DON stated without a care plan facility staff would not know how to have cared for the resident. The DON stated having a care plan in place was part of facility policy. During a review of the facility's Policy and Procedure (P&P) titled Out On Pass Therapeutic Leave dated 1/2025, the P&P indicated This facility ensures that resident and/or their representatives, as (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	applicable, are aware of the risks associated with leaving the facility and are provided with necessary information and support to make informed decisions prior to leaving. The interdisciplinary team completes a care plan for residents who choose to exercise their right for therapeutic leave, consistent with the resident's goals for care, and does not use therapeutic leave as a means of discharging the resident against their wishes or stated goals. During a review of the facility's P&P titled Develop-Implement Comprehensive Care Plans dated 1/2026, the P&P indicated The facility develops a person-centered comprehensive care plan that is culturally competent and trauma-informed, developed and implemented to meet each resident's preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.The comprehensive care plan describes: The services that are to be furnished are to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any Services that are not provided due to the resident's exercise of right to refuse treatment.Based on the comprehensive assessment. Facility staff shall work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices, and goals during their stay at the facility. The facility establishes, documents, and implements the care and services provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care plans shall describe the resident's needs and preferences and how the facility will assist in meeting these needs and preferences. 2. During a review of Resident 37's admission Record, the admission Record indicated the facility initially admitted the resident on 2/21/2023, and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke caused by a blocked blood vessel in the brain) affecting the right dominant (stronger more skillful) side and left non-dominant (less used) side, dysarthria (a motor speech disorder that weakens control of the muscles used for speaking), facial weakness, dysphagia (difficulty swallowing), and muscle weakness. During a review of Resident 37's Order Summary Report dated 10/20/2025, the Order Summary Report indicated LALM with bolsters (raised, air-filled sides) for skin maintenance. During a review of Resident 37's Physician Progress Note dated 1/13/2026, the Physician Progress Note indicated Resident 37 was bedbound, and nodded to simple questions. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 2/7/2026, the MDS indicated the resident had severe cognitive impairment (impaired ability to think, understand, and reason). The MDS indicated the resident had unclear speech and sometimes understood others and sometimes made self-understood. The MDS indicated Resident 37 was dependent on the staff (helper does all of the effort) for eating, oral (mouth) hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on and/or taking off footwear lying. The MDS indicated Resident 37 was at risk of developing pressure ulcers/injuries (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin). The MDS indicated Resident 37 utilized a pressure reducing device for bed and was on a turning/repositioning program. During a concurrent interview and record review on 3/19/2026 at 11:46 AM, with Registered Nurse (RN) 1, Resident 37's Order Summary Report and Complete Care Plan Report were reviewed. RN 1 confirmed there was no care plan for Resident 37's use of a LALM for skin integrity. RN 1 stated the resident should have had a care plan for the LALM. RN 1 stated the interventions for the LALM would have included how to manage the LALM's maintenance and function, placing the LALM at the correct (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	settings according to the medical doctor's orders. RN 1 stated care plans created an outline on how to care for the resident, and any licensed nurse could have created a care plan. RN 1 stated not having had a care plan for the LALM would not have aligned with the medical doctor's orders. During a concurrent interview and record review on 3/19/2026 at 11:57 AM, with the Director of Nursing (DON), Resident 37's Complete Care Plan Report was reviewed. The DON confirmed there was no care plan for the use of the LALM for skin integrity. The DON stated a care plan for the LALM should have been created to include interventions that would have included interventions to prevent pressure injuries and mattress settings. The DON stated any licensed nurse could have created a care plan and a care plan was a plan of care for Resident 37. During a review of the facility's policy and procedure (P&P) titled, Develop-Implement Comprehensive Care Plans dated 1/2026, the P&P indicated Each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs with seven days after the completion of the comprehensive assessment. The P&P indicated The comprehensive care plan describes the services that are to be furnished are to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The P&P indicated The interdisciplinary team, including the physician, a registered nurse, the resident or the resident's representative and other staff determined by the resident's needs will develop the care plan with corresponding interventions for care in accordance with professional standards of practice. The P&P indicated Care plans shall include the discipline providing care or services, measurable objectives, and timeframes to evaluate the resident's progress toward his/her goal(s).

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	056377	A. Building B. Wing	03/19/2026

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide skin and pressure ulcer (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin) prevention care consistent with professional standards of practice and per physician's orders for two of three sampled residents (Resident 12 and Resident 37) on Low Air Loss Mattresses (LALM, a specialized medical support surface designed to prevent and treat skin breakdown and pressure ulcers [localized damage to the skin and/or underlying tissue usually over a bony prominence]). By failing to ensure the LALM's were set at the appropriate level. This failure had the potential for Resident 12 and Resident 37 to develop skin breakdown and/or pressure ulcers. Findings: During a review of Resident 12's admission record, the admission record indicated the facility re-admitted the resident on 5/4/2025 with diagnoses that included dementia (a progressive state of decline in mental abilities), reduced mobility, the need for assistance with personal care, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right ankle, and flexion deformity (a condition where a joint becomes stiff and stuck in a bent position) of the left and right hip. During a review of Resident 12's Order Summary Report, the Order Summary Report indicated the resident had an active physician's order dated 12/1/2025 for a LALM for skin management. During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 1/20/2026, the MDS indicated the resident had severely impaired cognition (a profound decline in mental abilities such as memory, reasoning, and awareness that significantly hinders daily functioning and independence). The MDS indicated Resident 12 was dependent on help for oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 12 was at risk of developing pressure ulcers. The MDS indicated Resident 12 utilized a pressure reducing device for bed. During a review of Resident 12's Care Plan Report dated 1/26/2026, the Care Plan Report indicated the resident required the use of a LALM to relieve pressure and support the maintenance of skin integrity. The Care Plan Report indicated Resident 12 was at high risk of developing pressure ulcers which necessitated special pressure-reducing care. The Care Plan Report indicated a goal for Resident 12 was to have a reduced risk of the development of pressure injuries. The Care Plan Report indicated interventions that included ensuring Resident 12's LALM was in place, plugged in, and functioning properly. During a concurrent observation and interview on 3/16/2026 at 10:42 AM, with Licensed Vocational Nurse 3 (LVN 3), in Resident 12's room, Resident 12's was observed on a Serene Air LALM. Resident 12's LALM was observed to be off and deflated. LVN 3 stated Resident 12's LALM should have been turned on and placed on the second setting. LVN 3 stated he did not know how long Resident 12's LALM was turned off. LVN 3 stated the LALM had to be turned on to function properly. LVN 3 stated Resident 12 was on a LALM for skin management. LVN 3 stated Resident 12 was at risk of developing pressure ulcers. LVN 3 stated there was a potential for Resident 12 to develop skin breakdown (damage to the skin and underlying tissue, ranging from red, irritated skin to deep, open wounds/bedsores) if the LALM was not turned on and not functioning. Resident 12's LALM was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed to inflate after LVN 3 turned the resident's LALM on. During an interview on 3/19/2026 at 7:51 AM with Treatment Nurse 1 (TN 1), TN 1 stated Resident 12 was at a high risk of developing pressure ulcers. TN 1 stated Resident 12 was on a LALM to help maintain the resident's skin integrity. TN 1 stated because Resident 12's LALM was off for an unknown period of time, there was potential for Resident 12 to develop skin breakdown or a pressure ulcer. TN 1 stated Resident 12's LALM had to be turned on to ensure the LALM was functioning properly. During an interview on 3/19/2026 10:03 AM with the Director of Nursing (DON), the DON stated Resident 12 was using a LALM for skin maintenance. The DON stated Resident 12 was at high risk of developing pressure ulcers. The DON stated she did not know how long Resident 12's LALM was turned off. The DON stated Resident 12's LALM had to be turned on to function. The DON stated there was potential for Resident 12 to experience skin breakdown if the resident's LALM was off and not functioning for a long period of time. During a review of Resident 37's admission Record, the admission Record indicated the facility initially admitted the resident on 2/21/2023, and readmitted on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke caused by a blocked blood vessel in the brain) affecting the right dominant (stronger more skillful) side and left non-dominant (less used) side, dysarthria (a motor speech disorder that weakens control of the muscles used for speaking), facial weakness, dysphagia (difficulty swallowing), and muscle weakness (generalized). During a review of Resident 37's Order Summary Report dated 10/20/2025, the Order Summary Report indicated an active order for LALM with bolsters (raised, air-filled sides) for skin maintenance. During a review of Resident 37's Physician Progress Note dated 1/13/2026, the Physician Progress Note indicated Resident 37 was bedbound, and nodded to simple questions. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 2/7/2026, the MDS indicated the resident had severe cognitive impairment (impaired ability to think, understand, and reason). The MDS indicated the resident had unclear speech and sometimes understood others and sometimes made self-understood. The MDS indicated Resident 37 was dependent on the staff (helper does all of the effort) for eating, oral (mouth) hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on and/or taking off footwear lying. The MDS indicated Resident 37 was at risk of developing pressure ulcers/injuries (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin). The MDS indicated Resident 37 utilized a pressure reducing device for bed and was on a turning/repositioning program. During a review of Resident 37's Weights and Vitals Summary, the Weights and Vitals Summary indicated the resident weighed 97 pounds (lbs., a unit of weight) on 3/2/2026. During an observation in Resident 37' room on 3/16/206 at 12:06PM, Resident 37 was observed lying in bed, and awake. Resident 37's LALM was observed to be on and set to a range of 105-140 pounds. During a concurrent observation and interview on 3/17/2026 at 2:03 PM, with Treatment Nurse (TN)1, in Resident 37's room, Resident 37 was observed on a microAir 65 LALM with settings set between (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for one of five sampled residents (Resident 81) by failing to ensure Resident 81's bed was not left in a high position. This failure had the potential to increase Resident 81's risk for falls and injury such as broken bones. Findings:During a review of Resident 8's admission Record, the admission Record indicated the facility originally admitted Resident 8 on 4/14/2023 and readmitted Resident 8 on 3/12/2026 with diagnoses that included acute systolic congestive heart failure (a sudden, severe weakening of the heart's main pumping chamber meaning it cannot squeeze hard enough to push blood out to the body), muscle weakness, anemia (a condition where the body does not have enough healthy red blood cells), morbid obesity due to excess calories (a chronic condition where excessive calorie intake leads to extreme weight gain, typically 100 or more pounds over ideal weight), hemiplegia (paralysis - the loss of voluntary muscle function in part or most of the body, making it impossible to move affected areas) and hemiparesis (weakness) followed unspecified cerebrovascular disease (stroke or blood vessel issue in the brain occurred, but the specific cause is not detailed) affecting left non-dominant side, type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on supplemental oxygen (person's lungs cannot take in enough oxygen from the air to keep their blood oxygen levels healthy requiring a machine or tank to provide extra oxygen) and dementia (a progressive state of decline in mental abilities). During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool) dated 12/24/2025, the MDS indicated Resident 8 usually had the ability to understand others and usually had the ability to make herself (Resident 8) understood. The MDS indicated Resident 8 was dependent (helper does all of the effort and resident does none of the effort to complete the activity) for toileting, shower/bathing, upper/lower body dressing, putting on/taking off footwear (shoes and socks), personal hygiene (combing hair, applying makeup, washing/drying face and hands), transferring from bed to chair, and getting in/out of a tub/shower. The MDS indicated Resident 8 needed substantial/maximal assistance (helper does more than half of the effort) for rolling left and right in bed, sitting on the side of the bed to lying flat on the bed, and going from lying on the back to sitting on the side of the bed. During a review of Resident 8's Fall Risk Evaluation, dated 3/12/2026, the Fall Risk Evaluation indicated Resident 8 was at high risk for fall. During a review of Resident 8's Care Plan Report dated 3/13/2026, the Care Plan Report indicated Resident 8 was at risk for falls related to gait (a person's particular manner or style of walking)/balance problems, history of falls, poor safety awareness. The Care Plan Report indicated the goal was to minimize the risks of falls and injuries. During a review of Resident 8's Care Plan Report dated 3/13/2026, the Care Plan Report indicated Resident 8 was at risk for falls related to gait/balance, incontinence (the involuntary or accidental leakage of urine or poop due to a loss of bladder or bowel control), unaware of safety needs. The Care Plan Report indicated interventions to keep the furniture locked in position and to avoid repositioning furniture. During a review of Resident 8's History and Physical (H&P) dated 3/14/20226, the H&P indicated Resident 8 had decisional capacity (a person's ability to understand, reason through, and make a specific medical or personal decision at a particular time). The H&P indicated Resident 8 was taking Eliquis (a prescription blood thinner). During an observation on 3/16/2026 at 11:05 AM in the hallway outside of Resident 8's room, a star (sticker) was observed next to Resident 8's name on the wall outside of Resident 8's room indicating Resident 8 was a high risk for fall. Licensed Vocational Nurse 1 (LVN 1) was observed exiting Resident 8's room. During a concurrent observation and interview on 3/16/2026 at 11:06 AM with Resident 8 in Resident 8's room, Resident 8's bed was observed to be set to a high position. Resident 8 stated she (Resident 8) did not put the bed in high position. During a concurrent observation and interview on 3/16/2026 at 11:08 AM (continued on next page)

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	03/19/2026

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Certified Nurse Assistant 5 (CNA 5) and LVN 1, in Resident 8's room, Resident 8's bed was observed to be set to a high position. CNA 5 stated Resident 8's bed was in a high position since Resident 8 had therapy at 10:30 AM. LVN 1 stated he (LVN1) went into Resident 8's room to give Resident 8's roommate pain relief medication. LVN 1 stated he (LVN 1) should have lowered Resident 8's bed to a low position after giving Resident 8's roommate pain medication because Resident 8 was a high fall risk. During an interview on 3/17/2026 at 8:31 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 8 was a high fall risk, and the facility should have placed Resident 8's bed in a low position to prevent injury from a potential fall. RN 1 stated LVN 1 should have lowered Resident 8's bed on 3/16/2026 when LVN 1 was in the room when Resident 8's bed was set in a high position. During an observation on 3/17/2026 at 2:54 PM, in Resident 8's room, Resident 8's bed was observed to be in a raised (high) position. During a concurrent observation and interview on 3/17/2026 at 3:10 PM, in Resident 8's room, with the Director of Nursing (DON), Resident 8's bed was observed to be in a high position. The DON stated Resident 8's bed was slightly high. During a concurrent interview and record review on 3/17/2026 at 3:14 PM with the DON, the facility's Free of Accident Hazards/supervision/devices policy and procedure (P&P) dated 1/2025 was reviewed. The DON stated Resident 8 was at risk for fall and a factor that could result in Resident 8 having a fall was an incorrect bed height. The DON stated the P&P indicated factors that may result in resident falls but were not limited to incorrect bed height and/or width. During a review of the facility's P&P titled, Falling Star Program, dated 5/2022, indicated Residents identified with history of fall prior to admission and residents with a fall/multiple falls in the facility shall participate in the falling star program. The P&P indicated The Falling Star Program champion (DON) shall ensure that the program is implemented, monitored & sustained. During a review of the facility's P&P titled, Fall Management Program, dated 1/2025, the P&P indicated The facility strives to provide each resident with adequate supervision and assistance devices to minimize the risks associated with falls and to provide an environment which remains as free from accident hazards as possible. The P&P indicated Avoidable Accident: An accident which occurred because the facility failed to:identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or Evaluate and analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or Implement interventions, including adequate supervision and assistive devices (any tools, equipment, or software designed to help people with disabilities or age-related challenges live more independently), consistent with a resident's needs, goals, care plan, and current professional standards of practice to eliminate the risk, if possible, and, if not, reduce the risk of on occident; and/or Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice. During a review of the facility's P&P titled, Fall Management Program, dated 1/2025, the P&P indicated a definition of Hazards: Elements of the resident (in general) environment that have the potential to cause injury or illness. The P&P indicated a definition of Risk: To any external factor, facility characteristic (e.g., staffing or physical environment) or characteristic of an individual resident that influences the likelihood of an accident. The P&P indicated The facility educates employees at the time of hire, annually and as indicated on the facility policy Fall Management, included interventions to reduce injury and [NAME] related accidents.

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	03/19/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in accordance with professional standards to ensure food service safety by failing to: -Discard of expired chlorine (a powerful chemical cleaner/disinfectant used to kill germs) test strips (small, paper-based tools used primarily in commercial settings to measure the concentration of sanitizing chemicals in the final rinse cycle) used to monitor the chlorine chemical level in the facility' s dishwasher. -Discard of expired food items. -Properly labeled food items with a use by date (the last day a product should be consumed). -Label nine of ten drums of water containers. These failures had the potential to result in foodborne illness (food poisoning-illness from eating contaminated food containing bacteria[germs), and salmonella (a type of bacteria that causes a food-poisoning illness) which could lead to medical complications.Findings: During a concurrent observation and interview on 3/16/2026 at 8:49AM with the Dietary Supervisor inside the kitchen, the following were observed: 1. One open bottle of chlorine test paper strips with an expiration date of 11/2025. 2. One opened container of pickle relish not indicating a use by or expiration date. 3. One opened container of cherries not indicating a use by or expiration date. 4.One opened bottle of caramel sauce that had a use by date of 12/17/2025 on the label and an opened date of 3/8/2026 marked on the bottle. 5.One turkey sandwich that had a use by date of 3/14/2026 marked on the label. 6.One opened bag of tortillas that had a use by date of 2/28/2026. 7. One opened plastic bag of chicken that had a use by date of 3/9/2026. 8.One opened plastic bag of gelatin that had a use by date of 2/25/2026. 9.One opened plastic bag of white bread with an open date of 3/8/2026 and no use by date. During a concurrent interview of the kitchen with the DS on 3/16/2026 at 8:49AM, the DS stated that using expired chlorine test strip to check the level of the chemical ran the risk of having an inaccurate reading and could cause cross contamination (the transfer of harmful bacteria from one substance or object to another), and food borne illnesses. The DS stated the staff (in general) would not know if the dishwasher was sanitizing (lowering the number of germs on surfaces or objects to safe levels to prevent the spread of infection, often accomplished by using chemicals or heat) the dishes properly and residents (in general) could become ill. The DS stated residents (in general) could get sick if the residents (in general) would eat expired food items. The DS stated food items that were opened and not labeled with an expiration date or use by date, should have been discarded for safe practice. The DS stated without a label indicating an expiration date or use by date, kitchen staff (in general) would not know how long the food was good for. The DS stated the first kitchen staff member (unidentified) who opened the food item including himself should have checked for: the expiration date, the use by date, and should have labeled the food item with an open date and a use by date. The DS stated (continued on next page)

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	03/19/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired chicken could contain salmonella and could cause food poisoning. The DS stated expired food items should have been thrown away, residents may get sick and get food poisoning. During an interview on 3/18/2026 at 2:34 PM, with the Director of Nursing (DON), the DON stated if expired chemical test strips were used for the dishwasher there would be an incorrect reading, which would potentially result in bacteria (germs) not to be killed on everything that was being washed in the dishwasher. The DON stated residents (in general) could have gotten sick if they (residents) were served and ate expired food and could develop food poisoning. The DON stated it was the expectation that kitchen staff (in general) would check the expiration date for food items prior to use. The DON stated if residents (in general) were served chicken that was beyond the use by date, they could get sick, gotten food poisoning, and could have diarrhea since chicken contained salmonella and the facility had immune compromised (weakened immune system) residents. The DON stated it was not up to the residents to check the expiration date of their food. During a review of the facility's policy and procedure (P&P) titled, Washing and Sanitizing-Dietary dated 1/2026, the P&P indicated Improper test strips yield inaccurate results when testing for chemical sanitation. During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage dated 1/2026, the P&P indicated .staff must inspect.ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all foods stored in the refrigerator or freezer as indicated. The P&P indicated . removing foods not safe for consumption, .and rotating supplies. The P&P indicated .labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable) or discarded During a review of the facility's policy and procedure (P&P) titled, Food and Nutritional Services Equipment and Supplies dated 1/2026, the P&P indicated Spoiled or contaminated food shall not be stored or served. During an observation on 3/18 /2026 at 8:25 AM at facility's parking lot storage shelves, there were ten drums of water containers. One drum was labeled with Treatment date 12/12/2025 and nine drums were not labeled. During a concurrent observation and interview on 3/18 /2026 at 9 AM, with Maintenance Supervisor (MS), at the facility's parking lot storage shelves, ten drums of water were on the shelves. The MS stated the ten emergency water drums were designated potable water for staff (in general) and residents' (in general) consumption for drinking and kitchen use for food preparation and cooking. The MS stated the water was treated once a year to stay potable. The MS stated one drum was labeled with treatment date indicating it was a potable supply. The MS stated the facility did not label nine drums with treatment date to indicate water inside the drums were potable. The MS stated the nine drums should have been labeled to identify if the water was safe for consumption. The MS stated unlabeled drums could be consumed and potentially expose residents (in general) and staff (in general) to harmful bacteria. During a concurrent interview and record review on 3/18 /2026 at 9:13 AM with the MS, the facility's Emergency Water Supply log was reviewed. The MS stated the log indicated ten total drums were treated and stored on 12/12/2025 however the log did not identify each individual drum to ensure correlation between the documented treated water drums and the actual drums observed. The MS stated the drums one to ten should have been individually logged with treatment date and drums two (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to ten observed should have been individually labeled with treatment date to ensure the ten drums were potable emergency water supply. During an interview on 3/18/2026 at 3:05 PM, with the Infection Preventions (IP), the IP stated emergency potable water supplies were available to all residents (in general) and staff (in general). The IP stated emergency water supplies were intended for drinking water, cooking, and food preparation as needed. The IP stated that unlabeled emergency water containers did not ensure the water was safe for consumption and, if distributed, could potentially expose residents (in general) and staff (in general) to microorganisms, which may result in symptoms such as diarrhea, nausea, vomiting and stomach pain. During a concurrent interview and review on 3/19/2026 at 9:26 PM with the DON, photos of unlabeled potable water drum supplies were reviewed. The DON stated emergency potable water supplies were for drinking water and food preparation. The DON stated potable water supplies were free from bacteria and safe for consumption. The DON stated the water supply should be labeled in a way it indicated safe potable water supply. The DON stated the photos indicated one drum was labeled and nine drums were not labeled. The DON stated it would be unsafe to distribute water from unlabeled emergency water drums for consumption. The DON stated if water was provided from unlabeled containers, residents and staff may potentially consume contaminated water, leading to symptoms of stomach pain, diarrhea and vomiting. During a review of the facility's policy and procedure (P&P) titled Maintenance Services-Water Supply, last reviewed on 1/2026, the P&P indicated the purpose is to ensure a continuous, safe and potable water supply for resident care, sanitation, and facility operations in compliance with regulatory standards.

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	03/19/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Interdisciplinary Team (IDT, a collaborative group of healthcare professionals-including nurses, physicians, therapists, social workers, and dietitians-who work together to create and implement personalized care plans) and public patient representative (a trained advocate who acts for long-term care residents lacking decision-making capacity and family, ensuring their wishes or best interests are represented in medical decisions) convened (to come and bring together for a meeting) when one of five sampled residents (Resident 42) did not have the capacity to (the ability to use and understand information to make a decision and communicate any decision made) to provide an informed consent (voluntary agreement to accept treatment after receiving education regarding the risks, benefits, and alternatives to the treatment) for the treatment of Quetiapine Fumarate (Seroquel, a medication used to treat the symptoms of schizophrenia, a mental illness that is characterized by disturbances in thought). This failure had the potential to result for Resident 42 to receive unnecessary psychotropic (medication that affects mood, thoughts, behaviors, or perceptions) which could cause adverse side effects (an undesired, harmful, or unexpected reaction to a medication).Findings: During a review of Resident 42's admission Record, the admission Record indicated the facility re-admitted the resident from the General Acute Care Hospital (GACH) on [DATE] with diagnoses that included hepatic encephalopathy (brain dysfunction caused by advanced liver disease or failure), schizophrenia, dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought and emotions are so affected that contact is lost with reality). The admission Record indicated Resident 42 was self-responsible and under the IDT. During a review of Resident 42's Psychotherapeutic Drug Informed Consent Form dated [DATE], the Psychotherapeutic Drug Consent Form indicated a signature to verify the consent for Seroquel 25 milligrams (a unit of mass) three times a day for psychosis could not be obtained from the resident. The Psychotherapeutic Drug Informed Consent Form indicated the Assistant Director of Nursing (ADON) signed and confirmed that Resident 42 gave consent to treatment with Seroquel 25 mg three times a day for psychosis. During a review of Resident 42's History and Physical (H&P) dated [DATE], the H&P indicated the resident was not decisional. During a review of Resident 42's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated [DATE] for Seroquel 25 mg one tablet by mouth three times a day for psychosis manifested by aggressive behavior as evidenced by striking out at staff. During a review of Resident 42's Medication Administration Record (MAR) dated [DATE] to [DATE], the MAR indicated the resident received nine doses of Seroquel 25 mg. During a review of Resident 42's Medication Administration Record (MAR) dated [DATE] to [DATE], the MAR indicated the resident received 84 doses of Seroquel 25 mg. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated the resident had severely impaired cognition (a profound decline in mental abilities such as memory, reasoning, and awareness that significantly hinders daily functioning and independence). The MDS indicated Resident 42 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the resident completed activity) for eating and oral hygiene. The MDS indicated Resident 42 required partial/moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 42 was dependent on help for showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 42 was taking antipsychotic (medication used to treat psychosis) medication. During a review of Resident 42's Medication Administration Record (MAR) dated [DATE] to [DATE], the MAR indicated the resident received 54 doses of Seroquel 25 mg. During a review of Resident 42's IDT Progress Notes for Behavior Management dated [DATE] at 1:05 PM, the IDT Progress Notes for Behavior Management indicated the Psychiatric Nurse Practitioner (PNP) evaluated the resident and (continued on next page)

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	056377	A. Building B. Wing	03/19/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did a comprehensive review of the resident's current medication regimen. The IDT Progress Note for Behavior Management indicated the decision was made to persist with the current medication regimen as it appeared to be successfully managing the resident's symptoms and improving the resident's overall well-being. The IDT Progress Note for Behavior Management indicated the care team would continue monitoring Resident 42's progress and reassess the resident as needed in future follow-ups. During a concurrent interview and record review on [DATE] at 11:25 AM with Licensed Vocational Nurse 3 (LVN 3), Resident 42's Psychotherapeutic Drug Informed Consent Form dated [DATE] was reviewed. LVN 3 stated Resident 42 was oriented only to self and did not have the capacity to make decisions. LVN 3 stated Resident 42 had a physician order for Seroquel 25 mg three times a day. LVN 3 stated Resident 42 did not sign the Psychotherapeutic Drug Informed Consent Form dated [DATE], and indicated the form was signed by a licensed nurse (unidentified). LVN 3 stated that in the event a resident did not have the capacity to make decisions, the decision was handled by the IDT. LVN 3 stated the ADON and Social Services Director (SSD) were part of the IDT. During an interview on [DATE] at 9:39 AM with the Social Services Director (SSD), the SSD stated she (the SSD) was part of the IDT. The SSD stated she (SSD) was familiar with Resident 42. The SSD stated Resident 42 was confused and oriented only to self. The SSD stated Resident 42 did not have any family. The SSD stated Resident 42 did not have the capacity to make decisions. The SSD stated that when a resident (in general) did not have the capacity to make decisions, the decision was determined by the IDT. The SSD stated that in addition to the IDT the facility could also contact the patient representative hotline to help make decisions for Resident 42. The SSD stated the patient representative hotline was not contacted to discuss Resident 42 taking Seroquel. The SSD stated she (SSD) was not sure if Resident 42 had an IDT for behavioral management when he (Resident 42) returned from the GACH on [DATE]. During a concurrent interview and record review on [DATE] at 11:50 AM with the ADON, Resident 42's Psychotherapeutic Drug Informed Consent Form dated [DATE] and IDT Progress Note for Behavioral Management dated [DATE] were reviewed. The ADON stated she (the ADON) signed Resident 42's Psychotherapeutic Drug Informed Consent Form dated [DATE] for Seroquel 25 mg three times a day for psychosis. The ADON stated Resident 42 could not sign the Psychotherapeutic Drug Informed Consent Form because the resident did not have the capacity to make decisions. The ADON stated that when a resident (in general) did not have family, did not have a responsible party, and did not have the capacity to make decisions, the IDT could step in to help make decisions for the resident (in general). The ADON stated an IDT for behavioral management was not done when Resident 42 was re-admitted to the facility on [DATE]. The ADON stated an IDT for behavioral management should have been done to discuss Resident 42's change in capacity before she (the ADON) signed the resident's consent form for Seroquel. The ADON stated that the patient representative should have also been contacted for Resident 42. The ADON stated there was a potential for Resident 42 to experience unnecessary adverse side effects from psychotropic medication if the IDT and patient representative did not discuss if the resident should be on Seroquel. During an interview on [DATE] at 12:09 PM with the Director of Nursing (DON), the DON stated Resident 42 did not have the capacity to make decisions because the resident was confused and oriented only to self. The DON stated Resident 42 did not have any family. The DON stated Resident 42 was taking Seroquel 25 mg three times a day for psychosis. The DON stated consent was needed from Resident 42 to receive Seroquel but stated that because Resident 42 did not have the capacity to provide consent, the IDT should have reviewed the resident's medication and treatment options. The DON stated that when Resident 42 returned from the GACH on [DATE] the resident should have had an IDT for behavioral management to discuss Resident 42's lack of capacity before Resident 42 started taking Seroquel. The DON stated that the patient representative could have also been contacted to help make decisions for Resident 42. The DON stated there was a potential for Resident 42 to receive medication that was not needed if the IDT did not meet to discuss the resident taking Seroquel. During a review of the facility's Policy and Procedure (P&P) titled Dignity and (continued on next page)

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	03/19/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respect Psychoactive Medications dated 1/2026, the P&P indicated Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative shall be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a psychotropic medication. The resident's medical record shall include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternative that he or she preferred. The facility has written consent form which may serve as evidence of a resident's consent to psychotropic medication; and may have other documented evidence of the resident's consent or decline to treatment. During a review of the facility's P&P titled Informed Consent dated 1/2026, the P&P indicated In cases where the resident does not have the capacity to make decisions and there is no surrogate decision maker, the interdisciplinary team will: Review the physician's documentation of the resident and pertinent health information in the medical record. Review the medication intervention as outlined by the physician or designated licensed health professional. In collaboration with the primary care physician and Ombudsman: Discuss the resident desires, if known, through past conversations, interviews and discussions with family and friends. Review the type of medical intervention. Discuss the impact to the resident if the intervention was withheld. Discuss if there are any alternative interventions that could be discussed with the physician or licensed healthcare professional. Reach a decision and obtain physician orders if pertinent. The interdisciplinary team (IDT) will develop individualized care plans for the resident including resident condition, goals, and interventions, non-pharmacological interventions prior to administration, and target behaviors. The IDT will reevaluate the resident's condition at least once in every quarter for any changes in the resident's physical, mental, emotional and psychosocial well-being. During a review of the California Department of Aging Website dated 1/2026, the California Department of Aging Website indicated The Office of the Long-Term Care Patient Representative (OLTCPR) provides trained public representatives for specified long-term care residents who may need medical treatment but lack decision-making capacity and have no legally authorized surrogate.Under California Health and Safety Code S 1418.8, skilled nursing and intermediate care facilities may convene an interdisciplinary team (IDT) to make medical decisions for these residents. As of [DATE], facilities are required to include patient representatives on the IDT. If the facility cannot find a suitable person-such as a friend or family member-OLTCPR provides a trained public patient representative to help ensure the resident's rights, preferences, and dignity are supported in medical decision-making. Retrieved from: https://aging.ca.gov/providers_and_partners/office_of_the_long-term_care_patient_representative/

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	03/19/2026

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The Rehabilitation Center on Pico	3233 W. Pico Boulevard Los Angeles, CA 90019

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review the facility failed to ensure one of one sampled residents (Resident 12) was free from physical restraint (any physical, chemical, or mechanical device or method used to limit a patient's movement or restrict their freedom of movement, typically to prevent harm to themselves or others) as evidenced by placing Resident 12's bed against the wall without an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the resident's Responsible Party (RP, a specific individual or entity legally accountable for making healthcare decisions if the resident is unable to). This failure had the potential to affect Resident 12's dignity and result in the entrapment (an event in which a resident is caught, trapped, or entangled in the space) of the resident.Findings:During a review of Resident 12's admission Record, the admission Record indicated the facility re-admitted the resident on 5/4/2025 with diagnoses that included dementia (a progressive state of decline in mental abilities), reduced mobility, the need for assistance with personal care, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right ankle, and flexion deformity (a condition where a joint becomes stiff and stuck in a bent position) of the left and right hip. During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool) dated 1/20/2026, the MDS indicated the resident had severely impaired cognition (a profound decline in mental abilities such as memory, reasoning, and awareness that significantly hinders daily functioning and independence). The MDS indicated Resident 12 was dependent on help for oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 12 did not use restraints. During a review of Resident 12's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 1/26/2026 that indicated the resident may have the bed against the wall for safety every shift. During a review of Resident 12's Care Plan Report dated 2/10/2026, the Care Plan Report indicated the resident was at risk for falls related to confusion, incontinence (involuntary loss of control over bladder (urinary) or bowel (fecal) functions), poor communication/comprehension, and being unaware of safety needs. The Care Plan Report indicated a goal to minimize Resident 12's risk of injury from falls. The Care Plan Report indicated interventions that included keeping Resident 12's bed low with the bed against the wall for safety. During a concurrent observation and interview on 3/16/2026 at 10:42 AM, with Licensed Vocational Nurse 3 (LVN 3), in Resident 12's room, Resident 12's was observed lying in bed with a bed alarm (a tool that alerts caregivers when a person sits up or leaves their bed) and the right side of the bed against the wall. LVN 3 stated Resident 12's bed was against the wall to prevent the resident from falling out of bed. LVN 3 stated the bed against the wall could be considered a restraint, but indicated the facility had consent from Resident 12's RP to place the resident's bed against the wall. During an interview and record review on 3/18/2026 at 10:01 AM with Registered Nurse 1 (RN 1), Resident 12's informed consents (in general) were reviewed. RN 1 stated there was no informed consent for Resident 12's bed being against the wall from the resident's RP. RN 1 stated Resident 12 had a physician order for the bed to be against the wall for safety. RN 1 stated that Resident 12's bed was against the wall because the resident was at risk of falling. RN 1 stated Resident 12 was not alert or oriented (lacked awareness of their surroundings, current time, and/or identity) and had fallen out of bed in the past. RN 1 stated informed consent for the bed to be against the wall should have been obtained from Resident 12's RP because it could potentially limit the resident's movement. During a telephone interview on 3/19/2026 at 8:13 AM with RP 1, RP 1 stated she was responsible for making decisions for Resident 12. RP 1 stated she (RP1) was not informed that Resident 12's bed was placed against the wall prior to 3/18/2026. RP 1 stated she (RP1) was not informed of the reasoning, risks, or benefits of having Resident 12's bed against the wall prior to 3/18/2026. During an interview on (continued on next page)

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	03/19/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/19/2026 at 10:04 AM with the Director of Nursing (DON), the DON stated Resident 12's bed was against the wall for safety because the resident was at risk of falls. The DON stated Resident 9 would occasionally slide around in bed. The DON stated the nursing staff did not want to risk the resident falling off the bed. The DON stated the facility did not have an informed consent from Resident 12's RP for the bed being against the wall. The DON stated the RP should have been informed of the risk and benefits that involved having Resident 12's bed pushed against the wall. The DON stated informed consent should have been obtained for a bed against the wall because it could potentially restrict Resident 12's movement. During a review of the facility's Policy & Procedure (P&P) dated 1/2026, the P&P indicated The following practices shall be considered a physical restraint including, but not limited to placing a chair or bed close enough to a wall that the resident is prevented from risking out of the chair or voluntarily getting out of bed.Physical restraints may increase the risk of one or more of the following.Accidents such as falls, strangulation, or entrapment. Psychosocial impact related to the use of physical restraints may include one ore more of the following.loss of dignity, self-respect, and identity.feelings of imprisonment or restriction of freedom of movement.The licensed nurse shall obtain a physician's order for the use and specific type of restraint.Residents, or the resident representatives, may refuse the use of a restraint, even when medically warranted to treat a medical symptoms. During a review of the facility's P&P dated 1/2026, the P&P indicated It is the responsibility of the prescribing physician, or approved licensed healthcare provider, to personally examine and obtain a written informed consent, whereby applicable and indicated by state and federal regulations, from a resident or their representative for the use of physical restraints.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS - a resident assessment tool) for one of five sampled residents (Resident 81) was accurately completed. This failure had the potential to result in a delay in the necessary care and treatment for Resident 81.Findings:During a review of Resident 81's admission Record, the admission Record indicated the facility admitted Resident 81 on 2/9/2017 and readmitted Resident 81 on 11/5/2025 with diagnoses that included other reduced mobility, muscle weakness, dementia (a progressive state of decline in mental abilities), hemiplegia (paralysis - the loss of voluntary muscle function in part or most of the body, making it impossible to move affected areas) and hemiparesis (weakness) followed unspecified cerebrovascular disease (stroke or blood vessel issue in the brain occurred, but the specific cause is not detailed) affecting left non-dominant side and major depressive disorder, recurrent, unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 81's History and Physical (H&P) dated 1/29/2026, the H&P indicated Resident 81 could make her (Resident 81) needs known but could not make medical decisions. During a review of Resident 81's MDS dated [DATE], the MDS indicated Resident 81 usually could make herself (Resident 81) understood and usually had the ability to understand others. The MDS indicated the facility did not check the box for Depression under Section I - Active Diagnosis. During a review of Resident 81's Order Summary Report dated 3/19/2026, the Order Summary Report indicated an order for Escitalopram Oxalate (a prescription antidepressant that helps treat depression and anxiety) 5 mg (milligrams - metric unit of measurement, used for medication dosage and/or amount) - Give 1 tablet by mouth one time a day for Depressive d/o (disorder - disruption of normal, healthy functioning in the body) m/b (manifested by - shown by) verbalization (putting into words) sadness. During a concurrent interview and record review on 3/19/2026 at 8:47 AM with the MDS Licensed Vocational Nurse (MDS 1), Resident 81's admission Record was reviewed. MDS1 stated Resident 81's admission Record indicated Resident 81 had a diagnosis of major depressive disorder. MDS 1 stated Resident 81 had a diagnosis of major depressive disorder. During a concurrent interview and record review on 3/19/2026 at 8:47 AM with MDS 1, Resident 81's MDS dated [DATE] was reviewed. MDS1 stated Resident 81's MDS indicated the facility did not check the box for depression in Section I. MDS 1 stated the MDS was not accurate because the diagnosis of depression was missing. MDS 1 stated the MDS should be accurate so the facility could appropriately create a care plan for Resident 81. During a concurrent interview and record review on 3/19/2026 at 9:05 AM with the Assistant Director of Nursing (ADON), Resident 81's MDS dated [DATE] was reviewed. The ADON stated the MDS indicated the facility did not check the box for depression in Section I. The ADON stated the MDS was not accurate because the diagnosis of depression was missing. The ADON stated the MDS should be accurate so the facility could appropriately create a care plan for Resident 81. During a concurrent interview and record review on 3/19/2026 at 9:52 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Accuracy of Assessments, dated 1/2026 was reviewed. The DON stated the MDS needed to be accurate because the facility used the MDS for Resident 81's care planning. The DON stated the P&P indicated Accuracy of Assessments P&P indicated the P&P's intent was to ensure each resident (in general) receives an accurate assessment, reflective of the resident's (in general) status at the time of the assessment by staff qualified to assess relevant care areas and are knowledgeable about the resident's (in general) status, needs, strengths, and areas of decline. The Accuracy of Assessments P&P indicated a guideline of the assessment included the following: 2. The determination of appropriate participation of health professionals must be based on the physical, mental, and psychosocial (the interaction between a person's internal emotional/mental state and their external social environment) condition of each resident (in general). 5. The assessment must represent an accurate picture of the resident's status during the observation period (continued on next page)

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	056377	A. Building B. Wing	03/19/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the MDS. During a concurrent interview and record review on 3/19/2026 at 9:52 AM with the DON, the facility's P&P titled Resident Assessment, dated 1/2026 was reviewed. The Resident Assessment P&P indicated the MDS must minimally include a resident's (in general) mood and behavior patterns, psychosocial well-being, and disease diagnosis and health conditions. The DON stated the MDS needed to be accurate because the facility used the MDS for Resident 81's care planning.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review the facility failed to ensure one of three sampled residents (Resident 9) received assistance from the Restorative Nursing Assistants (RNAs) during meals as part of RNA feeding program (a specialized program that focuses on maintaining, improving, and encouraging a resident's functional independence during meals). This failure had potential for Resident 9 to have a decline in meal intake and experience weight loss.Findings: During a review of Resident 9's admission Record, the admission Record indicated the facility re-admitted the resident on 2/10/2026 with diagnoses that included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), urinary tract infection (UTI, an infection in the bladder/urinary tract), pneumonitis (inflammation of the lung tissue), and benign prostatic hyperplasia (BPH, enlargement of the prostate gland).During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool) dated 2/17/2026, the MDS indicated the resident had moderate cognitive impairment (a slight decline in thinking and memory). The MDS indicated Resident 9 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. The MDS indicated Resident 9 was on a mechanically altered diet (moist, soft-textured foods that are ground, minced, or chopped to require minimal chewing).During a review of Resident 9's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 3/12/2026 that indicated the resident was to be on the RNA feeding program for loss of appetite.During a concurrent observation and interview on 3/17/2026 at 12:40 PM with Certified Nursing Assistant 3 (CNA 3), in Resident 9's room, CNA 3 was observed setting up the meal tray for Resident 9 then leaving the resident to eat independently. CNA 3 stated Resident 9 was independent with feeding and could eat on his own.During an observation on 3/18/2026 at 8:10 AM, in Resident 9's Room, the resident was observed sitting up in bed with a breakfast meal tray in front of him on a bedside table. Resident 9 was observed attempting to feed himself. Resident 9 stated I don't like this food; I don't want to eat it. There were no staff observed at Resident 9's bedside.During an interview on 3/18/2026 at 8:22 AM with CNA 4, CNA 4 stated she was assigned to Resident 9. CNA 4 stated she was not assisting Resident 9 to eat because the resident was able to eat on his own and was independent with feeding. CNA 4 stated she did not know if Resident 9 was a part of the RNA feeding program.During a concurrent interview and record review on 3/18/2026 at 2:12 PM with the Director of Rehabilitation (DOR), Resident 9's physician orders were reviewed. The DOR stated Resident 9 had physician orders to be on the RNA feeding program. The DOR stated that Resident 9 was placed on the RNA feeding program because he (Resident 9) wasn't eating and had a loss of appetite. The DOR stated he (DOR) was responsible for informing the RNAs of the residents who were placed on the feeding program. The DOR stated he had not informed the RNAs that Resident 9 was to be on the feeding program. The DOR stated because Resident 9 was supposed to be on the RNA feeding program, the expectation was that the RNAs would be sitting at the resident's bedside, assisting the resident during meals, and encouraging the resident to eat. The DOR stated there was a potential for Resident 9 to not eat if the resident was not encouraged or assisted by staff during meals.During a telephone interview on 3/19/2026 at 8:03 AM with the Registered Dietitian (RD), the RD stated Resident 9 was placed on the RNA feeding program by the weight variance committee (a specialized team that reviews patients with significant and unexpected weight loss that implements interventions to manage and reverse declining health in residents). The RD stated the weight variance committee felt Resident 9 would consume more food during meals with RNA supervision. The RD stated the purpose of RNA supervision during meals was to assist, re-orient, and cue Resident 9 to continue eating. The RD stated if RNA supervision was not provided to Resident 9 during meals the resident could potentially not be able to improve with meal intake which could lead to additional weight loss.During an interview on 3/19/2026 at 9:53 AM with the Director of Nursing (DON), the DON stated Resident 9 was placed on the RNA feeding program for (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss of appetite. The DON stated Resident 9 should have been assisted by the nursing staff during meals. The DON stated the purpose of the RNA program was to provide encouragement and guidance to Resident 9 during meals so Resident 9 would be motivated to eat more. The DON stated if RNA supervision was not provided to Resident 9 during meals, the resident would not be encouraged to eat as much.During a review of the facility's Policy and Procedure (P&P) titled Restorative Feeding Program dated 1/2026, the P&P indicated The facility provides and each resident shall receive restorative feeding care as needed to help promote optimal independence with eating.A resident may participate in both Restorative and Rehabilitation Dining Program if appropriate. The goal is to reinforce and improve the residents' self-feeding and swallowing techniques as established by the therapy team.The RNA will provide cueing and assistance in the use of adaptive feeding techniques and equipment as instructed by the Occupational Therapist or Speech Therapist.Feeding status: moderate to supervised assist for self-feeding; supervised for use of swallowing techniques.Restorative Diet Aide: Responsible for the transport of RDP residents to the designated dining area. Responsible for implementing feeding program/plan as developed/per recommendation of OTR and/or SLP. Documenting progress on flow sheet and weekly summaries. Informing Dining Program Coordinator and/or Occupational Therapist, Speech - Language Pathologist of significant change in resident's status.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurse 4 (LVN 4) verified medication dosage prior to medication administration for one of seven sampled residents (Resident 31). As a result, Resident 31 received vitamin C (ascorbic acid, a nutrient crucial for immune function and wound healing) at a dose much higher than the dose prescribed. Placing residents at risk for medication errors and negative adverse effects. Findings: During a review of Resident 31's medication orders, the medication orders indicated an active order dated 2/18/2026 at 2:40 PM for ascorbic acid (vitamin C) 250 mg by mouth one time a day. During a medication administration observation on 3/18/2026 at 9:31 AM, LVN 4 was observed preparing medications for Resident 31. LVN 4 prepared 9 medications and 1 of those 9 medications was a tablet of vitamin C 500 milligrams (mg, a unit to measure mass). During concurrent observation and interview on 3/18/2026 at 11:06 AM, LVN 4 was asked to show the vitamin C bottles in the medication cart. LVN 4 looked and stated there was 1 bottle of vitamin C 500 mg; and confirmed there was no bottle of vitamin C 250 mg in the medication cart. During a concurrent review of Resident 31's medication orders, LVN 4 stated Resident 31's order was for Vitamin C 250 mg and there was no vitamin C 250 mg in the med cart. During a concurrent interview, LVN 4 stated he should have cut the 500 mg tablet in half or check the central supply closet for vitamin C 250mg. LVN 4 further stated he would contact the resident's physician and notify the physician the wrong dose given to Resident 31. During a concurrent observation of the facility's over the counter (OTC) medications supply closet and interview on 3/18/2026 at 2:48 PM, the director of nursing (DON) stated the facility did not have vitamin C 250 mg in stock; the facility had Vitamin C 500 mg. DON stated during medication administration, the practice was to check against the order for the correct medication and dosage. During a review of the facility policy and procedures, Administering Medications (January 2025), the policy indicated . Medications must be administered in accordance with the orders. The licensed nurse must check the label three times to verify the right resident, right medication, right dosage, right time, . before giving the medication.

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	056377	A. Building B. Wing	03/19/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control practices for one of five sampled residents (Resident 67) reviewed for infection control by failing to: -Ensure staff (in general) did not store the trash and soiled (dirty) linen carts inside shower room [ROOM NUMBER]. -Ensure staff (in general) cleaned shower room [ROOM NUMBER] after the Social Services Assistant (SSA) removed the trash and soiled linen carts before Certified Nursing Assistant 2 (CNA2) bathed Resident 67 on 3/17/2026 at 9:06 AM. This failure placed Resident 67 at risk of infection. Findings:During a review of Resident 1's admission Record, the admission Recorded indicated the facility admitted Resident 67 on 3/3/2009 and readmitted the resident on 6/23/2015 with diagnoses including right elbow contracture (a permanent tightening or shortening of muscles, tendons, skin, or tissues, usually replacing flexible tissue with inelastic, fiber-like tissue) and dysphagia (difficulty swallowing). During a review of Resident 67's History and Physical (H&P) dated 12/31/2025, the H&P indicated the resident did not have the capacity to make medical decisions. During a review of Resident 67's Minimum Data Set (MDS, a resident assessment tool) dated 2/24/2026, the MDS indicated Resident 67 had severely impaired cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 67 was dependent on mobility and activities of daily living (ADLs, activities such as bathing, lower body dressing and toileting a person performs daily). During an observation on 3/17/2026 at 9:06 AM in shower room [ROOM NUMBER], the SSA took the trash and soiled linen carts out from shower room [ROOM NUMBER]. The surveyor observed CNA 2 wheeled in Resident 67 directly for a bath before shower room [ROOM NUMBER] was cleaned. During an observation on 3/17/2026 at 9:16 AM, Resident 67 completed her (Resident 67) bath in shower room [ROOM NUMBER]. CNA 2 wheeled Resident 67 back to Resident 67's room. Following Resident 67's exit, the surveyor observed housekeeping staff (unidentified) entered shower room [ROOM NUMBER] to clean shower room [ROOM NUMBER]. During an interview on 3/17/2026 at 9:21 AM with CNA 1, CNA 1 stated the trash, and soiled linen carts should not be stored in the shower room. CNA 1 stated that the trash and soiled linen carts needed to be in the hallway. During an interview on 3/17/2026 at 10:41 AM with CNA 2, CNA 2 stated she (CNA2) took Resident 67 inside shower room [ROOM NUMBER] and did not consider infection control practices at that time. CNA 2 stated if she (CNA2) had to do it all over again, she (CNA2) would bring Resident 67 back into the room and would have called the environmental service to clean shower room [ROOM NUMBER] before Resident 67's bath. During a concurrent interview and record review on 3/18/2026 at 3:05 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Shower -tub room Cleaning, dated 7/2026 was reviewed. The DON stated the P&P indicated to assure all bathing areas were maintained in a clean and orderly fashion between and during resident bathing. The DON stated soiled linens should not be stored in the shower rooms. The DON stated that the facility did not follow infection control practices when shower room [ROOM NUMBER] was not cleaned and disinfected prior to Resident 67's bath. During a concurrent interview and record review on 3/18/2026 at 3:05 PM with the Infection Preventionist (IP), the facility's P&P titled Infection Prevention and Control Program, dated 7/2025 was reviewed. The IP stated the P&P indicated the facility established and maintained an Infection Control Program to provide safe and comfortable to help prevent infections. The IP stated that trash and soiled linen carts should be kept in the hallways and not stored in the shower rooms. The IP stated the shower room should be decontaminated if trash and soiled carts were stored inside the shower rooms. The IP stated CNA 2 should have ensured the shower room was clean before Resident 67 was given a bath. The IP stated that the facility failed to maintain a clean environment when shower room [ROOM NUMBER] was not disinfected prior to Resident 67's bath, creating the potential for cross contamination and possible infection [NAME] to Resident 67. During a review of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's P&P titled Shower-Tub Room cleaning, last reviewed on 1/2026, the P&P indicated that it is the responsibility of each CNA assisting residents with bathing and showering to keep the room clean and free of clutter.

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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 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the requirement for no more than four residents per room for one of 38 resident residential rooms (room [ROOM NUMBER]).This failure had the potential to result in inadequate space to provide necessary care, safe nursing care, and privacy for the residents in room [ROOM NUMBER].Findings:During a review of the facility's room waiver request letter dated 3/16/2026, the room waiver request letter indicated room [ROOM NUMBER] did not meet the 4 bed per room regulation.Room NumberRoom SizeNumber of Beds218543.98 sq ft6 The room waiver request letter indicated the rooms had no projections or other obstructions that would interfere with the free movement of wheelchairs and/or sitting devices. The room waiver request letter indicated that the rooms had enough space to provide for each resident's care, dignity, and privacy. The room waiver request letter indicated the rooms were in accordance with the special needs of the residents and would not have an adverse effect on the residents' health and safety. The room waiver request letter indicated the rooms would not impede the ability of any resident in the rooms to attain his/her highest practicable well-being. The room wavier letter indicated all measures would be taken to assure the comfort of each resident. During multiple room observations conducted in room [ROOM NUMBER] from 3/16/2026 to 3/19/2026, nursing staff (in general) were observed with adequate space to provide care to the residents in room [ROOM NUMBER]. Each resident in room [ROOM NUMBER] was observed to have curtains for privacy, working call lights, a dresser, television, and a bedside table. During an interview on 3/19/2026 at 8:47 AM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated he (LVN5) was assigned to care for the residents in room [ROOM NUMBER]. LVN 5 stated he (LVN5) had no concerns with the amount of space in room [ROOM NUMBER]. LVN 5 stated some residents in room [ROOM NUMBER] had wheelchairs which were easy to maneuver in and out of the room. LVN 5 stated the space in room [ROOM NUMBER] did not prevent him from providing quality care to the residents in the room. During an interview on 3/19/2026 at 9:04 AM with Resident 16, in room [ROOM NUMBER], Resident 16 stated he (Resident 16) did not have any issues or complaints about the amount of space in his room. Resident 16 stated his CNAs (in general) were able to change him and help move him without any problems. Resident 16 stated he (Resident 16) was happy with the amount of space he (Resident 16) had in room [ROOM NUMBER].The Department is recommending continuation of the room wavier request.

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	03/19/2026

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 16 of 38 resident rooms (rooms 101, 102, 103, 104, 110, 111, 112, 113, 214, 215, 216, 217, 219, 220, 221, and 222) met the requirement that each resident must have at least 80 square feet of useable living space in multiple resident rooms.This failure had the potential to result in the inadequate space necessary to provide safe nursing care and privacy for residents.Findings:During a review of the facility's room waiver request letter dated 3/16/2026, the room waiver letter indicated the facility requested a room variance for 16 resident rooms (rooms 101, 102, 103,104, 111, 112, 113, 214, 215, 216, 217, 219, 220, 221, 222, and 238). The room waiver letter indicated the following rooms had less than 80 square feet per bed:Room NumberFloor Area (square feet)Capacity101236.12 sq ft3102228.90 sq ft3103237.45 sq ft3104231.92 sq ft3110230.84 sq ft3111230.84 sq ft3112228.46 sq ft3113228.35 sq ft3214229.59 sq ft3215228.53 sq ft3216229.16 sq ft3217229.01 sq ft3219228.89 sq ft3220228.53 sq ft3221229.81 sq ft3222227.76 sq ft3 The room waiver request letter indicated the rooms had no projections or other obstructions that would interfere with the free movement of wheelchairs and/or sitting devices. The room waiver request letter indicated that the rooms had enough space to provide for each resident's care, dignity, and privacy. The room waiver request letter indicated the rooms were in accordance with the special needs of the residents and would not have an adverse effect on the residents' health and safety. The room waiver request letter indicated the rooms would not impede the ability of any resident in the rooms to attain his/her highest practicable well-being. The room wavier letter indicated all measures would be taken to assure the comfort of each resident. During an initial tour observation of the facility on 3/16/2026 from 9:30 AM to 11:30 AM, nursing staff (in general) were observed with adequate space to provide the care for the residents in each facility room. The residents were observed with the ability to move freely in the residents' rooms and throughout the facility. During an interview on 3/19/2026 at 8:59 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated he was assigned to care for the residents in rooms 101, 102, 103, and 104. LVN 4 stated he did not have any concerns about the space in the rooms. LVN 4 stated he did not feel crowded when passing medication to the residents. LVN 4 stated he could easily maneuver around the rooms when caring for residents. During a concurrent observation and interview on 3/19/2026 at 9 AM with Resident 66, in room [ROOM NUMBER], Resident 66 was observed lying in bed with a wheelchair, bedside table, oxygen concentrator (a medical device that filters nitrogen from ambient air to deliver concentrated, medical-grade oxygen to residents with respiratory conditions), and dresser at bedside. Resident 66 stated she (Resident 66) did not have any concerns regarding the space in the room. Resident 66 stated the Certified Nursing Assistants (CNAs) in general could easily provide care and maneuver the wheelchair in her room. Resident 66 stated she was quite happy with the space in room [ROOM NUMBER] because she could keep all her belongings and necessities nearby. During a concurrent observation and interview on 3/19/2026 at 9:13 AM with CNA 5, in room [ROOM NUMBER], CNA 5 was observed assisting a resident in a wheelchair back to bed. CNA 5 stated she had no complaints about the space in room [ROOM NUMBER]. CNA 5 stated she was able to move a wheelchair or shower chair in room [ROOM NUMBER] easily. CNA 5 stated the space in room [ROOM NUMBER] did not prevent her from being able to provide quality care to the residents.The Department is recommending continuation of the room waiver request.