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By 49571

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056195	A. BUILDING _____ B. WING _____	C 05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA BREA REHABILITATION CENTER	505 N. LA BREA AVENUE LOS ANGELES, CA 90036

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one complaint. Complaint number: CA00961708. The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number CA00961708 (Refer to F tag 689).	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure accident and hazard free environment for one of three sampled residents (Resident 1). The facility failed to ensure: 1. Resident 1 ' s bed footboard was not broken and left on the floor for several hours. 2. Resident 1 ' s feet (at ankle level) were not dangling at the foot of the bed. 3. Staff did report and request maintenance for the broken footboard.	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meir Rimon | TITLE: Administrator | (X6) DATE: 5/30/25

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.

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F 689	Continued From page 1 This deficient practice had the potential for Resident 1 to sustain fall and injury. Findings: A review of Resident 1 ' s admission record indicated Resident 1 was initially admitted to the facility on 2/29/2024 with a diagnosis of not limited to unspecified abnormalities of gait and mobility, encephalopathy (a disease damaged the functions of the brain), myocardial infarction (heart attack, happens when blood flow to the heart muscle is blocked). A review of Resident 1 ' s Minimum Data Set (MDS, a assessment tool) dated 3/9/2025 indicated, Resident 1 had a cognitive (mental action or process of acquiring knowledge and understanding) loss, unclear speech, has difficulty communicating to make self-understood, is wheelchair bound for mobility, requires maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) to sit and stand, to transfer from bed to chair. During an observation on 5/19/2025 at 10:35 AM, Resident 1 ' s bed footboard was broken and left on the floor. Resident 1 ' s feet at ankle level hanging at the foot of the bed. Resident 1 was observed lying in bed, right hand and lower extremities weakness. Resident 1 was unable to verbalize how long the footboard was left on the floor and the last time he was seen by a staff member. During an interview on 5/19/2025 at 12:15 PM with Licensed Vocational Nurse 1(LVN1) stated,	F 689		

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F 689	Continued From page 2 Resident 1 is dependent on staff for mobility, to turn in bed right or left. LVN1 observed Resident 1 ' s footboard broken and lying on the floor, Resident 1 ' s feet dangling. LVN1 stated, "I saw the footboard on the floor this morning, not sure of the exact time." Stated, it might have been broken, it was not supposed to be left on the floor. It is a safety hazard. Resident 1 could potentially slide down and fall. During an interview on 5/19/2025 at 12:29 PM with Restorative Nursing Assistant (RNA) stated, I saw Resident 1 ' s footboard on the floor while passing by the resident ' s room. I went into the room and tried to remove the broken piece because it is a safety hazard. I called for help and pulled Resident 1 up in bed because he was sliding down, the footboard is not in place to keep him from falling. During an interview on 5/19/2025 at 12:35 PM with Certified Nursing Assistant 1 (CNA1) stated, I am the assigned CNA for Resident 1. He has seen Resident 1 ' s bed footboard was broken and left on the floor since the beginning of his shift. CNA1 did not report to charge nurse, did not request for maintenance. CNA1 acknowledged observing Resident 1 ' s feet dangling because the footboard was not in place. CNA1 acknowledged the broken footboard is a safety hazard, could lead to Resident 1 ' s falling from bed. During an interview on 5/19/2025 at 12:55 PM with Facility Maintenance manager (FM), FM stated maintenance request log is checked every morning, there was no request for Resident 1 ' s room till moments ago. FM stated, I just found out about the repair requests. Resident 1 ' s	F 689		

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F 689	Continued From page 3 footboard was missing a screw and broken piece. The footboard needed to be replaced. Stated, any broken equipment is a safety risk potentially leading to accidents and falls. During an interview on 5/19/2025 at 1:10 PM with Registered Nurse supervisor (RN), RN stated, I conduct room rounds every two hours. I have not seen Resident 1 ' s bed broken. I have not seen Resident 1 dangling on bed. Staff are trained and expected to report environmental and resident safety risks immediately and request for maintenance. RN stated likely outcome for Resident 1 to slide down and fall. During an interview on 5/19/2025 at 1:47 PM with the Director of Staffing Development (DSD), DSD stated, facility staff is trained, and in-serviced, and daily reminders are provided to provide a safe environment for residents. Staff watch safety videos to prevent and report unsafe environmental issues. Staff are trained and expected to report on environmental hazards, resident safety concerns immediately and request for maintenance. Leaving Resident 1 dangling in bed is a fall risk. The broken piece should have been removed immediately and reported to supervisor and maintenance. During an interview on 5/19/2025 at 2:21 PM, the Director of Nursing (DON) stated, it is a resident neglect and safety concern not to report a broken bed and leaving a fall risk resident unattended. Licensed staff are expected to conduct room rounds, leaving a broken footboard for several hours is not according to the nursing standard of care. The time frame the broken footboard was not reported and Resident 1 left unattended is	F 689		

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F 689	Continued From page 4 concerning, it should have been caught by the licensed staff during the rounds. A review of the facility ' s Policy and Procedures (P&P) titled "Staffing, Sufficient and Competent Nursing" revied December 2024, the P&P indicated "Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: assuring resident safety; attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident." A review of the facility ' s P&P titled "Maintenance Service" revised December 2024 indicated, "The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times."	F 689		

- The Department heads will do a random inspection for any broken devices/equipment especially the bed footboard bi monthly x3 months . Any issues identified will be reported to the Administrator or DON/Designee during stand up meeting for immediate resolution as warranted.

- The DON (Director of Nursing) will present the results of the reviews and audits to the QAPI Committee monthly x 3 months for further review & recommendations.

Completion/ Compliance date: 6/1/25