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	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Brea Rehabilitation Center	505 N. LA Brea Avenue Los Angeles, CA 90036

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on observation, interview, and record review the facility failed to ensure one of three sampled residents (Resident 2), who had severe left knee pain was appropriately assessed in a timely manner. This failure resulted in the delay of care for Resident 2 who had to suffer from pain and discomfort for two days. Findings: During a review of the admission record for Resident 2 indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection (UTI- an infection in the bladder/urinary tract), dementia (a progressive state of decline in mental abilities), and hyperlipidemia (a condition where there are high levels of fats or lipids in the blood). During a review of Resident 2's skin assessment dated [DATE] indicated the skin was intact, with no abnormalities. During a review of Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 10/31/2024 at 1:16 pm, the SBAR and symptoms) of edema (swelling) or inflammation (a localized physical condition in which part of the body becomes reddened, swollen, hot, and often painful, especially as a reaction to injury or infection) observed in the left leg. Upon admission patient have right upper arm skin discoloration no open skin noted on her left leg and right upper arm I request an X-ray (X-rays are a type of radiation called electromagnetic waves. X-ray imaging creates pictures of the inside of your body) for her left leg and continue to monitor for change of conditions and V/S (vital signs-measurements of the body's basic functions, such as breathing rate, temperature, pulse rate, and blood pressure). During a review of an X-ray imaging report of Resident 2's Left tibia and fibula (two bones in your lower leg, also known as the shin bone [tibia] and the calf bone [fibula]) dated 10/31/2024, the indicated the X-ray report indicated there was no fracture (a break or a crack in a bone). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of an SBAR dated 11/2/2024 at 3:49 pm indicated, Left knee pain - Resident is noted with mild pain on Left knee with minor swelling. The SBAR indicated Resident 2 c/o mild pain while touched or moved. The SBAR indicated, It [left knee] is Warm to touch. Resident is kept clean, dry, and comfortable. Bed is at lowest position; call light is placed within easy reach. No fever or chills. No s/sx infection noted. [Family member (FM)] at bedside concerned the resident's condition. MD (medical doctor/Np (nurse practitioner) made aware by RN (registered nurse) supervisor and received new order x-ray and lidocaine 4% patch (a targeted pain medication used in areas such as arms, legs, back) to left knee daily for pain management. Order noted and carried out. [FM] at bedside notified of the new order and she verbalized understanding it. During a review of Resident 2's Nurse Progress note dated 11/2/2024 at 7:29 pm, the nurse progress note indicated, Resident [Resident 2] family called 911 (number called in the United States to contact the emergency services such medical, fire etc.) to transfer resident to ER (emergency room [the department of a hospital that provides immediate treatment for acute illnesses and trauma]) due to pain and swelling of right knee. Paramedics (a person specially trained to provide emergency medical services, as in or from an ambulance) came and transferred resident to the ER. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/2/2024, indicated Resident 2 had severe cognitive impairments (a condition that makes it difficult for a person to remember things, learn, concentrate, or make decisions). The same MDS indicated Resident 2 was dependent for all her Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an interview with Licensed Vocational Nurse 1 (LVN 1) on 11/21/2024 at 1:34 pm, LVN 1 stated that while Resident 2 's FM was visiting Resident 2 on 10/31/2024, Resident 2's FM informed LVN 1 that Resident 2 had pain to the left knee. LVN 1 stated LVN 1 assessed Resident 2's left leg and that Resident 2 was guarding her left leg when moving her left leg away from LVN 1. LVN 1 stated tried to touch Resident 2's left leg and the resident started crying in pain. LVN 1 stated [NAME] called the physician and requested an x-ray which indicated that Resident 2 did not have any fractures. During the same interview, LVN 1 stated that on 11/2/2024, Resident 2's FM was upset and told LVN 1 that Resident 2 had severe pain and that Resident 2's left knee was very swollen. LVN 1 stated that upon assessment, Resident 2's left knee was warm to touch, swollen, and painful. LVN 1 stated Resident 2's FM insisted that Resident 2 be sent to the ER. LVN 1 stated and admitted that Resident 2's situation should have been escalated given that Resident 2's condition was progressing to health conditions such as infection or DVT (Deep Vein Thrombosis- a condition where a blood clot forms in a large vein in the body, usually in the lower limbs). During an interview with the Interim Director of Nursing (IDON) on 11/22/2024 at 2:05 pm, the IDON stated that given that Resident 2's X-ray was negative for a fracture and that Resident 2 was still presenting with worsening symptoms (increased swelling, pain, and was warm to touch to the left knee), the situation should have been promptly escalated and notify a medical doctor (MD) and request an X-ray of the affected area (left knee) instead of the lower leg. During a review of a Policy and Procedures (P&P) titled Change in a Resident's Condition or Status, revised 2/2024, indicated Our facility promptly notifies the resident, his or her attending physician and the resident representative (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The same P&P indicated under policy interpretation and implementation. 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident. b. discovery of injuries of an unknown source. c. adverse reaction to medication. d. significant change in the resident's physical/emotional/mental condition. e. need to alter the resident's medical treatment significantly. f. refusal of treatment or medications two (2) or more consecutive times). g. need to transfer the resident to a hospital/treatment center, h. discharge without proper medical authority; and/or i. specific instruction to notify the physician of changes in the resident's condition.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45524 Based on interview and record review, the facility failed to effectively and timely manage/treat/assess the pain for two of three sampled residents (Resident 2 and Resident 3) . Resident 2 was experiencing severe pain of the left knee in the facility for two days Resident 3 was admitted to the facility for pain management (The process of providing medical care that alleviates or reduces pain). This deficient practice resulted in: Resident 2 was sent to a general acute care hospital (GACH) emergency room after the resident's family intervened and requested for the transfer to GACH. Resident 3 experiencing unnecessary pain affecting the resident's appetite and ability to sleep. Findings: 1. During a review of the admission record for Resident 2 indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection (UTI- an infection in the bladder/urinary tract), dementia (a progressive state of decline in mental abilities), and hyperlipidemia (a condition where there are high levels of fats or lipids in the blood). During a review of Resident 2's skin assessment dated [DATE] indicated the skin was intact, with no abnormalities. During a review of Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 10/31/2024 at 1:16 pm, the SBAR indicated: Resident 2 had complaint of leg pain and skin discoloration to RUA (right upper extremity [right arm]). The SBAR indicated Resident [Resident 2] C/O (complained of) of pain on her left leg, upon assessment no s/s (signs and symptoms) of edema (swelling) or inflammation (a localized physical condition in which part of the body becomes reddened, swollen, hot, and often painful, especially as a reaction to injury or infection) observed in the left leg. Upon admission patient have right upper arm skin discoloration no open skin noted on her left leg and right upper arm I request an X-ray (X-rays are a type of radiation called electromagnetic waves. X-ray imaging creates pictures of the inside of your body) for her left leg and continue to monitor for change of conditions and V/S (vital signs-measurements of the body's basic functions, such as breathing rate, temperature, pulse rate, and blood pressure). During a review of an X-ray imaging report of Resident 2's Left tibia and fibula (two bones in your lower leg, also known as the shin bone [tibia] and the calf bone [fibula]) dated 10/31/2024, the indicated the X-ray report indicated there was no fracture (a break or a crack in a bone). (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of an SBAR dated 11/2/2024 at 3:49 pm indicated, Left knee pain - Resident is noted with mild pain on Left knee with minor swelling. The SBAR indicated Resident 2 c/o mild pain while touched or moved. The SBAR indicated, It [left knee] is Warm to touch. Resident is kept clean, dry, and comfortable. Bed is at lowest position; call light is placed within easy reach. No fever or chills. No s/sx infection noted. [Family member (FM)] at bedside concerned the resident's condition. MD (medical doctor/Np (nurse practitioner) made aware by RN (registered nurse) supervisor and received new order x-ray and lidocaine 4% patch (a targeted pain medication used in areas such as arms, legs, back) to left knee daily for pain management. Order noted and carried out. [FM] at bedside notified of the new order and she verbalized understanding it. During a review of Resident 2's Nurse Progress note dated 11/2/2024 at 7:29 pm, the nurse progress note indicated, Resident [Resident 2] family called 911 (number called in the United States to contact the emergency services such medical, fire etc.) to transfer resident to ER (emergency room [the department of a hospital that provides immediate treatment for acute illnesses and trauma]) due to pain and swelling of right knee. Paramedics (a person specially trained to provide emergency medical services, as in or from an ambulance) came and transferred resident to the ER. During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 11/2/2024, indicated Resident 2 had severe cognitive impairments (a condition that makes it difficult for a person to remember things, learn, concentrate, or make decisions). The same MDS indicated Resident 2 was dependent for all her Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an interview with Licensed Vocational Nurse 1 (LVN 1) on 11/21/2024 at 1:34 pm, LVN 1 stated that while Resident 2 's FM was visiting Resident 2 on 10/31/2024, Resident 2's FM informed LVN 1 that Resident 2 had pain to the left knee. LVN 1 stated LVN 1 assessed Resident 2's left leg and that Resident 2 was guarding her left leg when moving her left leg away from LVN 1. LVN 1 stated tried to touch Resident 2's left leg and the resident started crying in pain. LVN 1 stated [NAME] called the physician and requested an x-ray which indicated that Resident 2 did not have any fractures. During the same interview, LVN 1 stated that on 11/2/2024, Resident 2's FM was upset and told LVN 1 that Resident 2 had severe pain and that Resident 2's left knee was very swollen. LVN 1 stated that upon assessment, Resident 2's left knee was warm to touch, swollen, and painful. LVN 1 stated Resident 2's FM insisted that Resident 2 be sent to the ER. LVN 1 stated and admitted that Resident 2's situation should have been escalated given that Resident 2's condition was progressing to health conditions such as infection or DVT (Deep Vein Thrombosis- a condition where a blood clot forms in a large vein in the body, usually in the lower limbs). During an interview with the Interim Director of Nursing (IDON) on 11/22/2024 at 2:05 pm, the IDON stated that given that Resident 2's X-ray was negative for a fracture and that Resident 2 was still presenting with worsening symptoms (increased swelling, pain, and was warm to touch to the left knee), the situation should have been promptly escalated and notify a medical doctor (MD) and request an X-ray of the affected area (left knee) instead of the lower leg. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of a Policy and Procedures (P&P) titled Change in a Resident's Condition or Status, revised 2/2024, indicated Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The same P&P indicated under policy interpretation and implementation. 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident. b. discovery of injuries of an unknown source. c. adverse reaction to medication. d. significant change in the resident's physical/emotional/mental condition. e. need to alter the resident's medical treatment significantly. f. refusal of treatment or medications two (2) or more consecutive times). g. need to transfer the resident to a hospital/treatment center, h. discharge without proper medical authority; and/or i. specific instruction to notify the physician of changes in the resident's condition. During a review of the P&P titled Pain - Clinical Protocol, revised 2/2024 indicated: -The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. a. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. - The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls. The same P&P indicated, The physician will help identify causes of pain; for example, by examining the resident directly, reviewing the resident's history, and via discussion with the resident and staff. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of the admission record for Resident 3 indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including multiple myeloma (a type of blood cancer that affects plasma cells in the bone marrow), neoplasm (an abnormal mass of tissue, also known as a tumor, that forms when cells grow and divide too much or don't die when they should) related pain (pain may arise from a tumor compressing or infiltrating tissue), and essential hypertension (HTN-high blood pressure). During a review of the MDS dated [DATE], indicated Resident 3 had moderate cognitive impairments. The same MDS indicated Resident 3 required substantial/maximal assistance for most of his ADL such as: (routine tasks/activities such as bathing, dressing, toileting hygiene). During a record review of Resident 3's SBAR dated 11/21/24 at 2:09 pm indicated, Pain is not relieved by Prn (as needed) narcotics (a substance used to treat moderate to severe pain). Asked Dr. to change Prn medications Norco Oral Tablet 10-325 MG (Hydrocodone-Acetaminophen - a combination medication that contains hydrocodone (an opioid) and acetaminophen (an analgesic). It's used to manage pain for people who've tried non-opioid medications but haven't gotten enough relief) *Controlled Drug* Give 1 tablet orally every 6 hours as needed for severe pain for 90 Days NTE 3gm/24 hrs. To Routine medications. During a review of Resident 3's SBAR dated 11/21/2024 at 11:25 pm, indicated, Abnormal labs elevated the WBC (White blood cells are part of the blood and are an important part of the immune system, which helps to detect and deal with infections). The same SBAR indicated, Labs [laboratory] results came with abnormality WBC 17.9 (range 4,500 and 11,000 per microliter of blood), MD (Medical Doctor) aware with order to send General Acute Care Hospital. During a concurrent observation and interview with Resident 3 on 11/21/24 at 9 am, Resident 3 was observed lying down in bed, positioned on 2 pillows. The resident appeared to be uncomfortable and was restless. Resident 3 was constantly trying to reposition himself at least every 30 seconds, was guarding his abdomen, and taking shallow rapid breaths. Resident 3 stated he had severe pain to his back but had recently received some pain medications. The resident stated that the pain causes him to lose his appetite. During an interview with Family Member 1 (FM)1 on 11/21/24 at 11:12 am, FM 1 stated Resident 3 was afraid to ask staff for pain medication for fear of retaliation. FM 1 stated Resident 1 is constantly pain which was the reason he was sent to the facility. FM 1 stated Resident 3 manifests pain by getting quiet, readjusting position, withdrawals, loses appetite and sleep. During a concurrent interview and record review of Resident 3's medical chart with Registered Nurse 1 (RN)1 on 11/22/24 at 11 am, RN 1 stated that Resident 3 was admitted to the facility for pain management due to neoplasm pain. RN 1 stated, It was very important that his [Resident 3] pain was treated. A review of the physician's order for Norco 10/325mg with RN 1 indicated to administer 1 tablet by mouth every 6 hours prn for severe pain to Resident 3. A review of the Norco administration log indicated Resident 3 received Norco as follows for the month of 11/2024: 11/2024 - once 11/3/2024 - twice (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/4/2024 - twice 11/5/2024- twice 11/6/2024 - once 11/7/2024 - once 11/12/2024 - once 11/14/2024 - once 11/20/2024 - once During a review of the SBAR dated 11/21/24 at 2:09 pm for Resident 3, the SBAR indicated RN 1 had completed/documented that the pain medications were not sufficient for Resident 3. RN 1 stated and confirmed that Resident 3 did not receive the targeted dose daily as ordered for Norco to determine if the Norco was effective or not. RN 1 stated that inadequate management of pain may lead to problematic symptoms for the resident such as insomnia, loss of appetite, and severe pain. Resident 3's oral intake was reviewed with RN 1. The oral intake indicated that Resident 3 was consuming between 0-to-25% of all meals. During a concurrent interview and record review of Resident 3's medical chart with the Director of Nursing (DON) on 11/25/24 at 10:40 am, the DON stated that Resident 3 was admitted for treatments which included pain management due to the neoplasm related pain. The DON admitted that even though pain is subjective, a faces pain scale would have been appropriate for Resident 3 that the pain scale given did not match his presentation. During a review of the facility's P&P titled Administering Medications,' revised 2/2024, indicated under policy interpretation and implementation: - Medications are administered in accordance with prescriber orders, including any required time frame. -Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. enhancing optimal therapeutic effect of the medication. b. preventing potential medication or food interactions. During a review of the P&P titled Pain - Clinical Protocol, revised 2/2024 indicated: -The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. - The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as gait disturbances, social isolation, and falls.