STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055161	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Crest Rehabilitation Center	909 Lucile Ave. Los Angeles, CA 90026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and implement 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 one of three sampled residents (Resident 1) assessed and identified as at risk of wandering(unsupervised movement within a secure area) and elopement (when a resident leaves/escapes from a facility without a physician's order and without the staff knowing) on 5/7/2026. This deficient practice had the potential for Resident 1 to have received inadequate care and/or supervision which led to Resident 1's elopement from the facility on 5/11/2026 and sustaining a fall.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 5/7/2026, with diagnoses that included parkinsonism (a progressive brain disorder that occurs when nerve cells in the brain die or become damaged) unspecified, fall, subsequent encounter (the healing or recovery phase of care), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), mild, without behavioral disturbance (acting out, agitated, aggressive or mood/personality changes), psychotic disturbance (hallucinations or strong delusions), mood disturbance (disruptive sadness, irritability), and anxiety (excessive worry, fear, and nervousness), major depressive disorder (a serious long lasting mental illness characterized by a consistent low mood, loss of interest in activities, and low energy), unspecified, personal history of transient ischemic attack (TIA-A temporary blockage of blood flow to the brain), and cerebral infarction (a stroke caused by a blocked blood vessel in the brain) without residual deficits(lasting physical or cognitive impairment that remain after a major event such as a stroke has been treated). During a review of Resident 1's History and Physical (H&P) dated 5/8/2026, the H&P indicated Resident 1 lacked capacity to make and understand decisions, cannot make know activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Situation Background and Recommendation form (SBAR: a form that is documentation of a complete assessment in response to a change in condition) dated 5/11/2026 at 7:00 PM, the SBAR form indicated: 6:45pm: Resident noted missing from wheelchair location in St [station] B. Notified all staff to search for resident in entire facility and surrounding area.7pm: 911 called.7:05pm: Informed wife7:26pm: [Local firefighter] called to notify that resident was found in [local intersection] and taken to [Local] ER due to skin abrasions related to fall during time outside facility. RP notified7:34pm: MD notified.7:40pm: [Local] ER called to inform resident will return to facility. Police arrived. During a review of Resident 1's General Acute Care Hospital (GACH) emergency department (ED) progress note dated 5/11/2026 at 8:16 PM, the ED progress note indicated Resident 1 was taken to the GACH by ambulance from the street to the ED after Resident 1 had wandered from the facility, had fallen, and injured his (Resident 1's) right elbow. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 5/13/2026, the MDS indicated Resident 1 had moderate cognitive impairment (impaired ability to think, understand, and reason). The MDS indicated Resident 1 needed (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substantial to maximal assistance (helper does more than half the effort) for oral (mouth) hygiene, personal hygiene, showering/bathing self, upper and lower body dressing. The MDS indicated Resident 1 was dependent on the staff (helper does all of the effort) for toileting hygiene. The MDS indicated Resident 1 needed partial/moderate assistance (helper does less than half of the effort) from sitting to stand and once standing able to have walked 10 feet. During a review of Resident 1's Care Plan Report, the Care Plan Report indicated there was no initial care plan for being at risk for wandering/elopement in Resident 1's medical record. During a concurrent interview and record review on 5/12/2026 at 3:34 PM, with Registered Nurse (RN)1, Resident 1's Nursing-Wander Risk assessment dated [DATE], and complete Care Plan Report were reviewed. RN 1stated Resident 1 was at risk for wandering on admission. RN 1 stated the purpose of creating a care plan for the risk of wandering/elopement was for the staff to have known how to monitor Resident , to ensured staff observed if Resident 1 was exhibiting behaviors of wandering or being an escapist (a resident who attempts to leave the facility without authorization or staff), and to have provided appropriate care and interventions for his behaviors. RN 1 confirmed by stating that when Resident 1 was assessed for being at risk for wandering on 5/7/2026, a care plan was not created for Resident 1, and there was no initial care plan specifically for being at risk of wandering/elopement. RN 1 stated a care plan would have been specifically based on Resident 1's initial assessment (evaluation) for risk wandering/elopement risk and MDS assessments. RN 1 stated Resident 1's care plan for elopement and wandering risk, was not created until after Resident 1 eloped from the facility on 5/11/2026. RN 1 stated if the staff had observed Resident 1 for wandering from day one (5/7/2026), any licensed nurse could have and should have initiated a care plan. RN 1 stated by not having had a care plan initiated for Resident 1 there were no interventions in place to prevent Resident 1 from eloping. RN 1 stated care plans were part of communication amongst staff and without a care plan the staff would not have known how to monitor Resident 1. During an interview on 5/12/2026 at 4:07 PM, with the Director of Nursing (DON), the DON stated care plans (in general) were a guide for a resident's condition, with a plan on how the staff were to address the condition and the level of care provided for the residents. The DON stated care plans were a guide for the staff to provide the best possible care for residents, including goals that were attainable and with interventions that were to be done in terms of nursing care. The DON stated care plans were created immediately when residents were admitted to the facility. The DON stated any licensed nurse could create, add a care plan, update, revise, adjust if an intervention did not work. The DON stated Resident 1 was at risk for wandering/elopement that was based on assessment when he (Resident 1) was admitted to the facility (5/7/2026). The DON stated all care was based on assessment and diagnosis such as Resident 1's diagnosis of Parkinson's disease and dementia as part of his risks for wandering/elopement. The DON stated by not having had a care plan for Resident 1's risk of wandering/elopement there could have been an incident that occurred before Resident 1's elopement that the staff would not have known about such as wandering into other residents' rooms or Resident 1 attempting to leave the facility. The DON stated a care plan would have had documented specific interventions in place for Resident 1. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated 1/2026, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated The comprehensive, person-centered care plan includes the resident's stated goals upon admission and desired outcomes. The P&P indicated Each resident's comprehensive person -centered care plan is consistent with the resident's rights to receive the services and/or items included in the plan of care. The P&P indicated Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. During a review of the facility's document titled, Charge Nurse/Nurse Supervisor dated 1/2026, indicated, Coordinate nursing care to accommodate resident's person-centered plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Charge Nurse/Nurse Supervisor document indicated Assist in coordinating nursing services with other resident services to ensure the continuity of the residents' plan of care. During a review of the facility's document titled, Registered Nurse (RN) dated 1/2026, indicated Consult and coordinate with the interdisciplinary team (IDT) and healthcare professionals to assess, plan, implement and evaluate individualized resident care plans. The RN document indicated Ensure initial baseline and periodic comprehensive assessments and care plans are completed within required timeframes.