

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055525	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Crenshaw Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 S Longwood Ave Los Angeles, CA 90016	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews and records review, the facility failed to ensure one of three sampled residents (Resident 1), did not elope (left the facility unsupervised) from the facility on 7/17/2026. The facility failed to: 1. Ensure Resident 1's elopement evaluation dated 11/21/2025 was completed, to accurately determine Resident 1's elopement risk. 2. Ensure Resident 1's care plan titled, Risk for Wandering/Elopement Identified, had intervention to minimize the resident's tendency to leave the facility unsupervised, as indicated in its Policy and Procedure (P&P) titled, Wandering and Elopements, which indicated, if a resident was identified at risk for wandering, elopement or other safety issues, the resident's care plan should include strategies and interventions to maintain resident's safety. 3. Monitor Resident 1 every one hour as indicated in the resident's care plan titled Elopement Risk. 4. Implement the facility's P&P titled, Exits or Means of Egress, which indicated to conduct regular checks and inspection of the alarm (alert when the door is opened) activation and alarm sounding to ensure the alarm system was functioning properly. These failures resulted in Resident 1 leaving the facility unsupervised on 7/17/2026, placing the resident at risk for accidents and injuries. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's was readmitted on [DATE]. Resident 1's diagnoses included paranoid schizophrenia (a mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), mood disorder (feelings may range from being very sad, empty or cranky to being very happy - going back and forth between each mood), and depressive disorder (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities). During a review of Resident 1's History and Physical (H&P) dated, 7/12/2026 the H&P indicated Resident 1 did not have the mental capacity to understand and make medical decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/25/2026, the MDS indicated Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 required supervision or touching assistance on staff with Activities of Daily Living (ADLs) such as dressing, toilet use, shower/bathing. Resident 1 required set-up or clean-up assistance with transferring and mobility. During a review of Resident 1's Elopement Evaluation dated 11/21/2025, the elopement evaluation was not completed. During a review of Resident 1's care plan titled Elopement Risk, revised 6/15/2026, the care plan indicated Resident 1 was identified as being at risk for leaving safe areas without authorization, secondary to mental illness, and sitting by exit doors. The care plan intervention indicated to monitor Resident 1 every one hour. During a review of Resident 1's care plan titled Risk for Wandering/Elopement Identified, revised on 6/15/2026, the interventions did not indicate monitoring and supervision measures for Resident 1. During a review of Resident 1's Change (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055525	Facility ID: 055525 If continuation sheet Page 1 of 3

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Condition (COC) dated 7/17/2026, the COC indicated, during changing shift rounds on 7/17/2026 at 11:00 p.m., Resident 1 was not in his room. Nursing staff searched for Resident 1 in common areas and Resident 1 was not found in the facility. During a review of Resident 1's General Acute Care Hospital (GACH) Emergency Department (ER) progress notes, dated 7/18/2026 at 6:07 p.m., the ER progress notes indicated, on 7/18/2026 at 11 a.m., Resident 1 was found by the police on the (unspecified) street, lying under hot weather, with hyperthermia (abnormally high internal (core) body temperature) and was unresponsive. During an interview on 7/20/2026 at 1:20 p.m. with the Receptionist, he stated that the emergency doors were checked every two hours and documented in a log. The receptionist stated, I lost the logs. The receptionist stated, I did not work on 7/17/2026 and the facility did not have a receptionist assigned to monitor the gates on that date. During a concurrent review of the 7/17/2026 facility video footage and interview on 7/20/2026 at 2:08 p.m. with the Director of Nursing (DON), the video review indicated the following: On 7/17/2026 at 8:50 p.m., Resident 1 was observed inside the facility, standing at the main entrance door that had a keypad. Resident 1 attempted to open the door, but the door was closed. No staff were observed at the main entrance/ patio. On 7/17/2026 at 8:54 p.m., Resident 1 was observed inside the facility by the main entrance (facing the street). No staff were observed. Resident 1 pushed the emergency exit door of the facility's main entrance with both hands and exited (left) the building. The DON stated that when Resident 1 pushed the emergency exit door opened, the alarm did not activate (went off). The DON stated staff did not check if the alarm was locked or was functioning properly. The DON the alarm did not sound because it was not turned on. The DON stated Resident 1's elopement could have been prevented if the emergency exit door alarm was activated. During an interview on 7/20/2026 at 1:20 p.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 1 was last seen on 7/17/2026, at approximately 8:30 p.m. CNA 3 stated around 10:50 p.m., the incoming shift CNA went to Resident 1's room and found that he was not in the room. CNA 3 stated that he did not know Resident 1 was at high risk for elopement. CNA 3 stated that it was important to check residents often (unspecified) for their safety to prevent him (Resident 1) from eloping. During an interview on 7/21/2026 at 1:00 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 1 was not considered a high risk for elopement. LVN 3 stated that she did not know what the procedures were in monitoring the residents or how often Resident 1 should have been monitored. During a concurrent interview and record review on 7/21/2026 at 1:58 p.m., with Registered Nurse (RN) 1, Resident 1's Elopement Evaluation, Risk for Wandering/Elopement, dated 11/21/2025 and the Elopement Risk care plans were reviewed. RN 1 stated that the Elopement Evaluation dated 11/21/2025 was not completed. RN 1 stated not completing Resident 1's Elopement Evaluation affected the resident's care. RN 1 stated the staff should have supervised Resident 1 every hour or frequently due to his elopement risk as indicated in the resident's care plan titled Risk for Elopement. RN 1 stated that the Wandering/Elopement care plan did not indicate how often Resident 1 should be monitored. RN 1 stated that failing to create Resident 1's personalized care plan resulted in Resident 1 not receiving proper supervision. During an interview on 7/21/2026 at 3:32 p.m. with the Director of Nursing (DON), the DON stated the Receptionist was required to check the doors and alarms every two hours and document the results. The DON stated nurses did not check Resident 1 every one hour and as needed. The DON stated that licensed nurses must check on residents every two hours at a minimum. The DON stated it was the facility's responsibility to know Resident 1's whereabouts and to maintain appropriate safety measures. During a review of the facility's P&P titled, Exits or means of Egress, dated 1/2019, the P&P indicated the facility should conduct regular alarm check/ inspection to ensure that alarm system is functioning properly, including alarm activation, alarm sounding. During a review of the facility P&P (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Wandering and Elopements, dated 3/2023, the P&P indicated, if a resident was identified at risk for wandering, elopement or other safety issues, the resident's care plan should include strategies and interventions to maintain resident's safety. During a review of the facility P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2023, the P&P indicated, comprehensive, person-centered care plan should describe the services to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.		