

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/24/2025
NAME OF PROVIDER OR SUPPLIER  Angels Nursing Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  415 S Union Avenue Los Angeles, CA 90017	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36395</p> <p>Based on interview and record review the facility failed to investigate and determine how a resident got out of the facility for one of three sampled residents (Resident 1). For Resident 1, who was found in the facility ' s parking lot on 4/13/25, the facility failed to determine how Resident 1 left her room unattended and was found in the facility ' s parking lot.</p> <p>This deficient practice had the potential for Resident 1 to leave the facility unattended again and potentially be exposed to danger.</p> <p>Findings:</p> <p>During a review of the Admission Record indicated the facility initially admitted Resident 1 on 2/25/14 and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and anxiety disorder.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS, a resident screening tool) dated 1/22/25 indicated Resident 1 had moderately impaired cognitive skills. Resident 1 needed supervision with shower/bathe self, set-up or clean-up assistance with oral hygiene/toileting hygiene, upper/lower body dressing, putting on/taking off footwear, personal hygiene and independent with eating.</p> <p>During a review of Resident 1 ' s Elopement Risk assessment dated [DATE] at 3:43 p.m., indicated Resident 1 had intermittent confusion, ambulatory and was at risk for elopement.</p> <p>During an interview on 4/24/25 at 9:04 a.m., guard 1 stated Resident 1 was found in the parking lot on 4/13/25. Guard 1 stated the facility ' s location is not in a very good neighborhood. Guard 1 stated Resident 1 can be exposed to danger when Resident 1 leaves the facility unattended.</p> <p>During a telephone interview, on 4/24/25 at 10:08 a.m., guard 2 stated he saw Resident 1 standing in the parking lot adjacent to the facility. Guard 2 stated he does not know how Resident 1 got to the parking lot but thinks that Resident 1 may have exited from the window of Resident 1 ' s room. Guard 2 stated he escorted Resident 1 back inside the facility.</p> <p>(continued on next page)</p>

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:  Facility ID: 055704	If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/24/25 at 10:30 a.m., licensed vocational nurse (LVN) 1 stated Resident 1 was found in the parking lot on 4/13/25. LVN 1 stated she does not know how long Resident 1 was in the parking lot. LVN 1 stated guard 2 found Resident 1 in the parking lot and escorted Resident 1 back inside the building. LVN 1 stated she did not document because Resident 1 was found in the facility property. LVN1 stated it is important to monitor Resident 1 ' s whereabouts because Resident 1 was a wanderer and to ensure Resident 1 is safe.</p> <p>During an interview on 4/24/25 at 11 a.m., the director of nursing (DON) stated LVN 1 notified the DON that Resident 1 was found in the parking lot. DON stated he does not know how Resident 1 left her room and was found in the parking lot. DON agreed there was no documentation of the incident.</p> <p>During an interview on 4/24/25 at 12:36 p.m., the administrator (ADM) stated the facility did not investigate how Resident 1 left her room and was found in the facility parking lot. ADM stated there was no red flag because Resident 1 was found within the facility property.</p> <p>During a review of the facility's policy and procedures (P&amp;P) titled Safety and Supervision of Residents revised on 7/24, the P&amp;P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision, and assistance to prevent accidents are facility-wide priorities. The same Policy indicated our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The interdisciplinary team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment including adequate supervision and assistive devices.</p>		