STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055918	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Sol Post Acute	16910 Woodruff Ave. Bellflower, CA 90706

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 interview and record review the facility failed to ensure one of two sampled residents (Resident 1) did not elope from the facility on 6/2/2025 at 1:30 p.m. The facility failed to: 1.Accurately assess Resident 1 for wandering (walk around without any clear purpose or direction) and elopement risk to prevent the resident from leaving the facility unsupervised. 2. Ensure on 6/2/25 at 1:30 p.m. Resident 1 was supervised while he was on the patio. 3. Ensure staff followed facility's policy and procedure (P&P) titled, Elopement and Wandering Residents dated 12/19/2022, which indicated facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. These deficient practices resulted in Resident 1 eloping (a situation in which a resident leaves the premises or a safe area without the facility's knowledge and supervision, if necessary) from the facility on 6/2/2025 at 1:30 p.m. These deficient practices placed Resident 1 at risk for exposure to harsh environmental conditions (rain and/or cold), injury from motor vehicle accidents, medical complications related to his diagnosis of depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and paranoid schizophrenia (mental illness characterized by delusions and hallucinations) without receiving prescribed medication including abilify (antipsychotic medication treats schizophrenia) and trazadone (medication to treat depression), lack of food with the risk of malnutrition (health problems that may arise due to lack of nutrients), dehydration (abnormally low fluid levels in the body), and possible death. As of 6/8/2025 Resident 1 was found and was admitted to general acute care hospital (GACH). Resident 1 was discharged from GACH back to the community on 6/8/2025. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including anxiety (intense, excessive, persistent worry about everyday /situations), depression and paranoid schizophrenia. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's History & Physical (H&P) dated 6/1/25, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1s Minimum Data Set (MDS - a resident assessment tool) dated 6/2/2025, the MDS indicated Resident 1's cognition was intact. The MDS also indicated Resident 1 was independent (resident completes activity by themselves) with Activities of Daily Living (ADLs- activities such as eating, dressing and toileting a person performs daily). The MDS also indicated Resident 1 had diagnosis of anxiety, depression and schizophrenia. During a review of Resident 1's Clinical admission dated 5/29/2025 the Clinical admission indicated Resident 1's goal was to return home (alone). During a review of Resident 1's Elopement Risk assessment dated [DATE], the Elopement Risk Assessment indicated Resident 1 was assessed as wanderer (random or repetitive locomotion. This movement may be goal-directed (e.g., the person appears to be searching for something such as an exit) or may be non-goal-directed or aimless). The Elopement Risk assessment also indicated Resident 1 was a low risk for elopement. During a review of Resident 1's Order Summary Report dated 6/5/2025, the Order Summary Report indicated Resident 1 had orders for abilify 5miligram (mg-unit of measurement) mg give one tablet by mouth one time a day for schizophrenia manifested by (m/b) auditory hallucinations (experiencing sounds, especially voices, that are not physically present). The Order Summary Report also indicated Resident 1 had orders for trazadone 100 mg one tablet by mouth at bedtime for depression m/b inability to sleep. During a review of Resident 1's care plan titled Resident 1 is an Elopement Risk/Wanderer, dated 5/30/2025, the care plan goal indicated for Resident 1's safety to be maintained. The care plan indicated interventions including to distract Resident 1 from wandering by offering pleasant diversions, structured activities, food, conversation, television, book, and for residents who are at risk of elopement related to history of homelessness develop a trusting and respectful relationship, show empathy and understanding towards the resident's past experiences with homelessness and collaborate with them to develop an individualized plan of care. The care plan also indicated to identify pattern of wandering . intervene as appropriate. During an interview on 6/4/2025 at 3:32 p.m., with the Receptionist, the Receptionist stated that the last time she saw Resident 1 he was on the patio on 6/2/2025. The Receptionist stated that she did not see Resident 1 leave the facility, as her computer was facing the wall and not in the line of site of the front door. The Receptionist stated she thinks that Resident 1 got past her when she was making a copy or taking a message because she never left her area and facility staff had found a wheelchair next to the front door. During a phone interview on 6/4/2025 at 4:05 pm with Resident 1's emergency contact (EC). The EC stated that she had not heard from Resident 1. The EC stated he usually calls her every two weeks when he gets money. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 6/5/2025 at 10:10 a.m., with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 6/2/2025 was the first time to take care of Resident 1. LVN 1stated that the last time she saw Resident 1 was on 6/2/2025 around 12:40 p.m., in his room. LVN 1 stated at 12:51 when the physical therapist went to look for Resident 1 for physical therapy treatment, Resident 1 was gone. Facility staff started to look for Resident 1 and at 1:30 pm the facility called a code white (missing person). LVN 1 stated Resident 1 did not express wanting to leave the facility. During a concurrent interview and record review on 6/5/2025 at 12:33 p.m., with the Registered Nurse (RN) Resident 1's admission Inquiry dated 5/19/2025 and his medical records dated 5/29/2025 through 6/2/2025 were reviewed. The admission Inquiry indicated Resident 1 was nicotine dependent and was a current every day smoker of 20 cigarettes daily for years. The admission inquiry also indicated that Resident 1 drinks alcohol beverages. The elopement assessment indicated Resident 1 did not have a history of drug/alcohol abuse and that Resident 1 did not have a history of homelessness. The RN stated that Resident 1's elopement assessment was not accurate Resident 1's admission inquiry indicated he was a smoker and drank alcohol. The RN stated Resident 1's care plan for elopement indicated Resident 1 was homeless and the elopement risk assessment indicated Resident 1 was not homeless. The RN stated when you don't have accurate assessments your care plan will be inaccurate, and the residents care will not be appropriate for the resident's condition. The RN stated Resident 1's elopement could have been avoidable with the correct assessment and interventions in place. During an interview on 6/5/25 at 4:20 pm with the Director of Nursing (DON), the DON stated Resident 1's elopement assessment was inaccurate. The DON stated when assessments were not correct your plan of care will not be correct, there will be discrepancies in the information, and it will affect the care the resident was receiving. The DON stated Resident 1's elopement was avoidable. During a review of the facility's policy and procedure (P&P) titled admission of a Resident dated 12/19/2022. The P&P indicated The admission process is intended to obtain all possible information regarding the resident for the development of the comprehensive plan of care, and to assist the resident in becoming comfortable in the facility. Residents are admitted to the facility under orders of the attending physician. Licensed Nursing does Assessment. Developing a Plan of Care, a baseline care plan will be developed within 48 hours of a resident's admission. Screen for falls, pressure injuries, elopement and incontinence. During a review of the facility's policy and procedure (P&P) titled Elopement and Wandering Residents dated 12/19/2022, the P&P indicated This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. Residents will be assessed for risk of elopement and unsafe wandering, when clinically appropriate, by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements.