STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056148	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casitas Care Center	10626 Balboa Blvd. Granada Hills, CA 91344

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. 40537 Based on interview and record review, the facility failed to implement its policy and procedure titled Wandering (to walk around without any clear purpose or direction) and Elopement (leaving the facility without notice or permission) and failed to ensure one of three sampled residents (Resident 1), who was observed with periods of confusion, agitation (a condition in which a person is unable to relax and be still) and was observed wandering and entering other resident rooms on 4/7/2025 was kept free from accidents and hazards by: 1. Failing to ensure Certified Nursing Assistant 1 (CNA 1) followed the facility's policy and procedure titled Wandering and Elopement to attempt to prevent Resident 1, who was at risk for unsafe wandering, from leaving the facility premises. These deficient practices resulted in Resident 1 leaving the facility on 4/7/2025 at 11:10 p.m., without being stopped by CNA 1, who observed Resident 1 leave the facility. These deficient practices placed Resident 1's health and well-being at risk and could result to Resident 1 sustaining severe injury requiring hospitalization and death. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the facility admitted Resident 1 on 4/7/2025 with diagnoses that included type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and asthma (a respiratory disease that causes difficulty in breathing). During a review of Resident 1's Admission Summary Progress Notes, dated 4/7/2025, timed at 6:52 p.m., the Admission Summary Progress Notes indicated Resident 1 was observed with periods of confusion and agitation. The Admission Summary Progress Notes further indicated Resident 1 was observed wandering and entering other resident rooms. (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 Health Status Note, dated 4/8/2025, timed at 1:34 a.m., the Health Status Note indicated that on 4/7/2025 at 10:30 p.m., Licensed Vocational Nurse 1 (LVN 1) observed Resident 1 sleeping in his (Resident 1) bed. The Health Status Note indicated that on 4/7/2025 at 11:20 p.m., while LVN 1 was providing care to another resident (not specified), LVN 1 was notified by a CNA (referring to CNA 1). The Health Status Note further indicated that CNA 1 saw Resident 1 on 4/7/2025 at 11:10 p.m. walked out of the building and did not know Resident 1 was a resident because Resident 1 was wearing his own clothes. During a review of Resident 1's Health Status Note, dated 4/8/2025, timed at 7:30 a.m., the Health Status Note indicated that on 4/8/2025 at 10:40 a.m., a call was received from the local law enforcement informing the facility that Resident 1 was found and was taken to General Acute Care Hospital 1 (GACH 1) for evaluation. During an interview on 4/15/2025, at 2:43 p.m., with CNA 1, CNA 1 stated that on 4/7/2025 at 11:10 p.m. he (CNA 1) saw Resident 1 leaving the facility but did not stop Resident 1 from leaving the facility because Resident 1 was wearing street clothes and was walking totally normal, he (referring to Resident 1) wasn't shuffling (to move or walk in a sliding dragging manner without lifting the feet) at all. CNA 1 then stated on 4/7/2025, about ten minutes later (after Resident 1 left the facility) a staff (not specified) informed him that Resident 1 was missing. CNA 1 stated that was when he (CNA 1) realized that the man he saw leaving the facility was probably Resident 1. CNA 1 stated that he did not but should have stopped the man he saw leaving the facility and asked the man to identify himself or who he had been visiting. CNA 1 further stated that even though Resident 1 may have been alert and oriented and safe to leave the facility as he wished, even at night, CNA 1 could not be certain of that because he did not stop Resident 1 and ask him questions. CNA 1 also stated that therefore, given that the time was well after dark, and that Resident 1 was not wearing reflective clothing, even if he had been alert and oriented with a normal walking gate, he (Resident 1) still could have been hit by a car or have fallen without being easily seen by others in the dark, which could have resulted in serious injury, hospitalization and death. CNA 1 stated that in the future, if ever he (CNA 1) sees someone leave the facility who he does not recognize, he (CNA 1) will immediately stop that person and ask them to identify themselves. In the event that person is a resident who wants to leave, CNA 1 stated he will not physically prevent the resident from leaving because the resident has a right to leave the facility at any time if the resident choose to, but CNA 1 will at least call for help from other staff and try to recommend to the resident to remain in the facility at least until the staff can call their responsible party or try to redirect the resident. During an interview on 4/15/2025, 3:51 p.m., with the Director of Nursing (DON), the DON stated that the specific failure of the facility in this instance was that CNA 1 saw someone leave the building after dark who CNA 1 did not recognize and did not at least try to stop and identify them. The DON stated CNA 1 should have immediately stopped the person who turned out to be Resident 1 and at least tried to identify them. The DON stated that because it was well after dark, and that Resident 1 was not wearing reflective clothing, even if Resident 1 had been alert and oriented with a normal walking gate, he still could have been hit by a car or have fallen without being easily seen by others, which could have resulted in serious injury, hospitalization and death. The DON stated that all staff will be trained to stop anyone trying to leave the building after dark and attempt to identify them and call for help from other staff if that person turns out to be a resident wanting to leave the facility so that staff can call the responsible party and try to redirect them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Wandering and Elopements, last reviewed in 1/3/2025, indicated it is the policy of the facility to identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner; b. get help from other staff members in the immediate vicinity, if necessary; and c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises.