STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056195	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Brea Rehabilitation Center	505 N. LA Brea Avenue Los Angeles, CA 90036

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 observation, interview, and record review, the facility failed to provide adequate supervision and implement effective interventions to prevent elopement (when a resident leaves the facility grounds or a designated safe area without the staff knowing and/or without the supervision the resident needs) for one of three sampled residents (Resident 1) who had no capacity to understand or make decisions and had a history of elopement by failing to:1. Accurately assess and identify Resident 1's elopement risk on 9/17/2025, 12/19/2025, 3/19/2026, and 4/30/2026.2. Update Resident 1's care plan on 4/30/2026 after she (Resident 1) eloped from the facility.As a result, Resident 1 eloped from the facility on 4/30/2026 between approximately 2 pm to 3 pm, was found by law enforcement around 7 pm on 4/30/2026 and returned to the facility.A review of Resident 1's admission record indicated that Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN-high blood pressure), and dysphagia (difficulty swallowing). During a review of Resident 1 ' s Minimum Data Set (MDS - a standardized assessment tool) dated 3/19/2026, the MDS indicated Resident 1 had moderate cognitive impairment (a stage between normal aging and dementia, where a person has noticeable memory or thinking problems that are clear to others, but they can still handle everyday tasks). The MDS indicated Resident 1 supervision or touching assistance from staff for most of her Activities of Daily Living (ADLs such as eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene). During a review of Resident 1's elopement risk assessments dated 9/17/2025, 12/19/2025, and 3/19/2016 indicated that Resident 1 was not an elopement risk. During a review of Resident 1's history and physical (H&P - when a physician assesses and interviews a patient then documents findings) dated 9/19/2025 indicated Resident 1 did not have the capacity to understand and make decisions. During a review of the care plan with the focus, The resident is an elopement risk/wanderer r/t History of attempts to leave facility unattended, Impaired safety awareness, initiated on 9/30/2025 indicated under interventions that Resident 1 was missing from the facility. During a review of Resident 1's facility Situation Background Assessment Recommendation (SBAR- a tool used in healthcare to improve patient safety by enabling fast, accurate, and concise information transfer between clinicians) dated 4/30/2026 at 11 p.m. indicated that Resident 1 The resident was mentioned to want Filipino food and wanted to buy some food. The SBAR indicated that the 7 am to 3 pm Licensed Vocational Nurse (LVN) had seen Resident 1 upstairs in the activity room during a cooking class and that the Facility Administrator (FA), Director of Nursing (DON) and the Registered Nurse Supervisor (RNS) were notified around 4:15 pm that Resident 1 was missing. During an interview with LVN 1 on 5/2/2026 at 1 pm, LVN 1 stated that Resident 1 liked the wander the hallways and often triggered the alarms because she had a wonder guard (a wearable patient-monitoring system often disguised as wristband and triggers alarms on exits when a wearer gets near it) on. LVN 1 stated that she was assigned to work with Resident 1 on 4/30/2026 which was the day that she (Resident 1) successfully left the facility. LVN 1 (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	could not recall the last time she had seen Resident 1 but stated that Resident 1 had gone to a cooking class at some point in the afternoon. LVN 1 stated that exit to the stairway had an alarm which triggered whenever a resident with a wander guard goes in close proximity. LVN 1 confirmed that the elevator did not have a wander guard alarm and was not guarded by staff. During an interview with the Receptionist (RCPT) on 5/5/2026 at 10 am, RCPT stated that her role in preventing elopement were to ensure that she screened all residents who came to the lobby on their way out. RCPT stated that if she was not sure about their ability to leave independently, she called the nurses station to confirm with nursing staff. RCPT stated that she was aware of the resident who were at risk for elopement but did not have a list or binder which she could refer to confirm on who was at risk for elopement. During a concurrent interview and record review of Resident 1's elopement risk assessments and care plan for elopement risk with the DON on 5/5/2026 at 11:58 am, the DON stated that Resident 1 independently went to the activity room which was on the third floor (Resident 1 resided on the second floor). A review of the elopement risk assessments dated 9/17/2025, 12/19/2025, and 3/19/2016, the DON confirmed that answers to the following questions were answered as a no when in fact they should have been answered as yes.Does the resident have a diagnosis of depression?Is the resident on a psychoactive medication?Does the resident ambulate independently with or without the use of an assistive device such as a walker, cane, or wheelchair?If a resident has wandering behavior, is it tied to resident's past such as prior work, taking long walks, seeking someone they cannot find?The DON confirmed that Resident 1 had a diagnosis of depression, was on psychoactive medications, ambulated independently, and had a history of wandering. The DON stated that answering the above questions incorrectly showed that Resident 1 was not an elopement risk which was inaccurate. The DON stated that she was at the facility the day that Resident 1 eloped from the facility and did not remember hearing the alarm get triggered. The DON stated that by the time she left the facility around 5 pm, Resident 1 had not been located but that she had learned that Resident 1 was located close to her previous apartment. The DON stated that the front desk/receptionist should have a list at the front desk as a second check to ensure that the residents that need monitoring are monitored. During a review of the facility's policy and procedures (P&P) titled, Wandering and Elopements, revised 1/2026, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The same P&P indicated that residents who are identified as at risk for wandering, elopement, or other safety issues will have a care plan including strategies and interventions to maintain the resident's safety.