

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: 056244	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Grand Park Convalescent Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 2312 West 8th Street Los Angeles, CA 90057	
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 - Some	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 record review, the facility failed to: Maintain a safe and functional environment for one of three sampled residents (Resident 1) by monitoring Resident 1's whereabouts in the facility as indicated in Resident 1 comprehensive care plan for elopement (the act of leaving a facility unsupervised without prior authorization) precaution. Properly evaluate one of three sampled residents (Resident 1)'s Elopement Risk Evaluation (ERE - a numerical score used to determine the likelihood of a person, often a patient in a care setting, leaving a facility without authorization or staff knowledge) dated 6/4/2026. Reevaluate Resident 1's ERE after Resident 1 had eloped from the facility on 6/4/2026, 6/22/2026 and 7/15/2026 according to facility's policy and procedures (P&P) titled, Wandering, Unsafe Resident. Revised Resident 1's Care Plan (CP) for elopement after Resident 1 had a change of condition on 6/4/2026 and 6/22/2026. These deficient findings resulted in Resident 1 eloping on 7/15/2026 and missing from the facility, Resident 1 was returned to the facility on 7/16/2026 where Resident 1 was found with a circular skin discoloration on the right side of neck, back of neck and left side of neck during skin evaluation on 7/16/2026. Cross Reference F657 Findings: During a review of the admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), unspecified dementia (a progressive state of decline in mental abilities) and altered mental status (refers to a significant disturbance in a person's perception, thinking, memory, or level of consciousness). During a review of Resident 1's History and Physical (H&P) dated 6/5/2026, the H&P indicated that Resident 1 does not have the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS - resident assessment tool) dated 6/7/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Care Plan (CP), initiated on 6/4/2026, for elopement precaution, the CP indicated a goal of, (Resident 1) will have no episodes of leaving the facility without notice. Resident 1's CP indicated interventions including, monitoring of whereabouts in facility, and to place wander guard (an electronic safety network used in care facilities consisting of a wearable tag, door sensors, and staff alerts. It prevents confused residents from wandering outside) to resident's right ankle to minimize the possibilities of losing resident's location. During a review of Resident 1's CP, initiated on 6/3/2026 for impaired cognitive function/dementia or impaired thought processed related to dementia, difficulty making decisions and wandering, the CP indicated (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 - Some	interventions including to, Cue, reorient and supervise as needed. During a review of Resident 1's ERE, dated 6/4/2026, the ERE score was 17 (suggests that while the individual isn't at the highest risk, there are factors present that increase their likelihood of eloping), the ERE indicated: (Resident 1) has no diagnosis or history of Alzheimer's (a disease characterized by a progressive decline in mental abilities) or Dementia. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/4/2026, the SBAR indicated, (Resident 1)'s episode of went out of the facility without assistance. During a review of Resident 1's SBAR, dated 6/22/2026, the SBAR indicated, Episode of elopement. During a review of Resident 1's SBAR, dated 7/15/2026, the SBAR indicated, Resident (1) left the facility at approximately 11:15 a.m. without staff supervision. Resident (1)'s current physical location is unknown. During a review of Resident 1's SBAR, dated 7/16/2026, the SBAR indicated, Upon return, (Resident 1) noted with circular red discolorations to right side of neck, back of neck, and left side of neck during skin evaluation. During a review of Resident 1's medical records, there was no ERE completed for Resident 1 after Resident 1 eloped on 6/4/2026, 6/22/2026 and 7/15/2026. During a review of Resident 1's Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) meeting, dated 6/10/2026, the IDT meeting discussion indicated, Since admission, resident has consistently expressed desire to return home. Resident (1) remained ambulatory without an assistant device and is able to independently leave the facility. Intermittent confusion has been noted; however, resident (1) continues to verbalize his wishes clearly and consistently. During an interview with Resident 1's family member 1 (FM 1) on 7/17/2026 at 11:59 a.m., FM1 stated, facility did not monitor and provided a 1:1 supervision to Resident 1 while in the facility, which resulted in Resident 1's leaving the facility without staff's assistance and knowledge. FM 1 stated, Resident 1 has dementia and flight risk. FM 1 stated, they had a meeting with facility's staff regarding Resident 1's plan of care which they agreed to provide Resident 1 with 1:1 sitter to closely monitor Resident 1. FM 1 stated, facility failed to provide the necessary supervision. FM 1 stated, Resident 1 had attempted to leave the facility many times and on 7/15/2026, Resident 1 left the facility and was missing throughout the whole night. FM 1 stated, Resident 1 was unable to tell him where Resident 1 spent the night of 7/15/2026 and facility was unable to find Resident 1. FM 1 stated, he was the one who found Resident 1 on 7/16/2026. During an interview with Certified Nursing Assistant 1 (CNA 1) on 7/17/2026 at 1:41 p.m., CNA 1 stated, Resident 1 did not have any 1:1 sitter assigned to him. CNA 1 stated, when Resident 1 eloped on 7/15/2026, he was assigned to Resident 1 and he last saw him around 9 a.m., walking to the bathroom and was moving around the facility on his own. CNA 1 stated, he was very busy that day and he did not see how Resident 1 was able to leave the facility on his own. CNA 1 stated, I couldn't do anything because I was so busy. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 7/17/2026 at 3:01 p.m., LVN 2 stated, on 7/15/2026, when Resident 1 had eloped from the facility, she was not aware that Resident 1 left the facility without staff's knowledge and they were busy that day as she was charge nurse, LVN 2 stated, I was busy giving medications to other residents. During a concurrent interview and record review with Director of Nursing (DON) on 7/17/2026 at 4:52 p.m., DON reviewed Resident 1's ERE dated 6/4/2026, and stated, the Resident 1's ERE was not evaluated accurately, DON stated, Resident 1's has a diagnosis of dementia and that should be included in the questionnaire during ERE. DON stated, there was no ERE completed after 6/4/2026, 6/22/2026 and 7/15/2026 when Resident 1 had attempted and eloped from the facility. DON stated that residents should be reevaluated for elopement risk whenever there is an incident of residents leaving the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility without staff's assistance and knowledge. DON stated that there should be a reevaluation done so that they may do any modifications needed to do with resident's plan of care. DON further reviewed Resident 1's SBAR dated 6/4/2026, 6/22/2026 and 7/15/2026 and Resident 1's CP for risk of elopement. DON stated and confirmed, Resident 1 eloped from the facility and left without staff's assistance, DON stated, there was no revision done regarding Resident 1's CP for elopement when Resident 1's had a change of condition due to eloping on 6/4/2026 and 6/22/2026. DON stated, there should be a revision on Resident 1's CP so that they adjust and modify the interventions on Resident 1's plan of care. During a review of the facility's P&P titled, Wandering, Unsafe Resident, release date 1/2026, the P&P indicated, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as detailed monitoring plan will be included. During a review of the facility's P&P titled, Accidents and Incidents - Investigating and Reporting, review date 1/2026, the P&P indicated, All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. 2. The following data, as applicable, shall be included in the investigation: a. The date and time the accident or incident took place; b. The nature of the injury/illness (e.g., bruise, fall, nausea, etc.); c. The circumstances surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's Attending Physician was notified, as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, including his/her vital signs; j. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); k. Any corrective action taken; l. Follow-up information; m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report. During a review of the facility's P&P titled, Resident Assessments, reviewed date 1/2026, the P&P indicated that, Comprehensive MDS assessment include both the completion of the MDS as well as completion of the CAA process and care planning. Non-comprehensive MDS assessment include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. Information in the MDS assessment will consistently reflect information in the progress notes, plans of care, and resident observations/interviews. The results of the assessments are used to develop, review, and revise the resident's comprehensive care plan.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to revise a care plan for at risk of elopement (leaving the facility unsupervised and without staff knowledge) for one of three sampled residents (Resident 1), who left the facility unsupervised and without staff assistance and knowledge on 6/8/2026 and 6/22/2026. This deficient practice had the potential to place Resident 1 at risk for recurrent elopement. During a review of the admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood), unspecified dementia (a progressive state of decline in mental abilities) and altered mental status (refers to a significant disturbance in a person's perception, thinking, memory, or level of consciousness). During a review of Resident 1's History and Physical (H&P) dated 6/5/2026, the H&P indicated that Resident 1 does not have the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS - resident assessment tool) dated 6/7/2026, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Care Plan (CP), initiated on 6/4/2026, for elopement precaution, the CP indicated a goal of, (Resident 1) will have no episodes of leaving the facility without notice. Resident 1's CP indicated interventions including, monitoring of whereabouts in facility, and to place wander guard (an electronic safety network used in care facilities consisting of a wearable tag, door sensors, and staff alerts. It prevents confused residents from wandering outside) to resident's right ankle to minimize the possibilities of losing resident's location. During a review of Resident 1's CP, initiated on 6/3/2026 for impaired cognitive function/dementia or impaired thought processed related to dementia, difficulty making decisions and wandering, the CP indicated interventions including to, Cue, reorient and supervise as needed. During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 6/4/2026, the SBAR indicated, (Resident 1)'s episode of went out of the facility without assistance. During a review of Resident 1's SBAR, dated 6/22/2026, the SBAR indicated, Episode of elopement. During a review of Resident 1's SBAR, dated 7/15/2026, the SBAR indicated, Resident (1) left the facility at approximately 11:15 a.m. without staff supervision. Resident (1)'s current physical location is unknown. During a review of Resident 1's Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) meeting, dated 6/10/2026, the IDT meeting discussion indicated, Since admission, resident has consistently expressed desire to return home. Resident (1) remained ambulatory without an assistant device and is able to independently leave the facility. Intermittent confusion has been noted; however, resident (1) continues to verbalize his wishes clearly and consistently. During an interview with Resident 1's family member 1 (FM 1) on 7/17/2026 at 11:59 a.m., FM1 stated, facility did not monitor and provided a 1:1 supervision to Resident 1 while in the facility, which resulted in Resident 1's leaving the facility without staff's assistance and knowledge. FM 1 stated, Resident 1 has dementia and flight risk. FM 1 stated, they had a meeting with facility's staff regarding Resident (continued on next page)		

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