STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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 - Immediate jeopardy to resident health or safety 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 was assessed at risk for wandering (walking around without a clear purpose) and elopement by failing to: 1. Accurately assess and identify elopement risk. The facility's Wandering & Elopement assessment dated [DATE] indicated a Low Probable Risk even though Resident 1 demonstrated repeated exitˆseeking, wandering, and attempts to elope on [DATE]. RN 2 stated the assessment was inaccurate and should have reflected a Moderate Actual Risk (is where a hazard is present and has a fair or intermediate likelihood of occurring). 2. Identify the sliding door in Resident 1's room and in Rooms 126, 128, 130, 132, 134, 136, and 138 as a potential elopement route and evaluate the need for an alarm or other safety device on this exit, despite the resident's repeated exitˆseeking behavior. 3. Identify the two patio gates at the back of the facility that leads to Avenue 1 and Street 2 as a risk and did not install alarms prior to Resident 1's elopement. 4. Implement the interventions outlined in the Elopement Risk/Wanderer Care Plan (CP - is a structured, individualized document created by healthcare professionals in collaboration with the patient to outline specific health conditions, treatment goals, and necessary services) to ensure the resident is properly evaluated for the need for increased supervision and close monitoring, including continuous visual observation. 5. Revise and strengthen elopement interventions despite Resident 1 demonstrating repeated and escalating exitˆseeking behaviors during both the 7 a.m.-3 p.m. and 3 p.m.-11 p.m. shifts on [DATE]. As a result of these deficient practices, Resident 1 eloped from the facility on [DATE] between 7:54 a.m. and 8:30 a.m. and was not found by facility staff. At approximately 11 p.m. on [DATE], an unidentified individual called 911 (the telephone number used to reach emergency medical, fire, and police services) after finding Resident 1 on the street. Emergency responders reported that the resident had been robbed, beaten, and set on fire. Paramedics (are advanced allied health professionals in the Emergency Medical Services (EMS) system who provides critical,, life-saving prehospital care to patients) found Resident 1 lying unconscious on the ground with burns to the neck, shoulders, face, scalp, and back, and with swelling of the face and tongue. The resident was transported to General Acute Care Hospital (GACH 2), arriving on [DATE] at 12:23 a.m., and was subsequently transferred to GACH 3. On [DATE] at 9:45 a.m., Resident 1 expired at GACH 3. On [DATE] at 5:04 PM and while onsite, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) in the presence of the Administrator (ADMIN) and Director of Nursing (DON) due to the failure to properly supervise Resident 1 and not have effective interventions in place to prevent elopement. On [DATE] between 7:54 a.m. and 8:30a.m., Resident 1 eloped from the facility. On [DATE] at about 11 p.m., emergency responders found the resident on the street, unconscious, robbed, beaten, and burned. The resident was taken to GACH 2 and transferred to GACH 3 on [DATE], (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	where the resident passed away. On [DATE] at 6:48 p.m., while onsite at the facility, the SSA removed the IJ in the presence of the ADMIN and DON, after the facility submitted an acceptable IJ Removal Plan (IJRP- interventions and implementation to correct the deficient practices) which was verified and confirmed through observation, interview, and record review. Although the IJ was removed, the facility remained out of compliance with F689 (is a federal regulation for long-term care facilities (nursing homes) under the Centers for Medicare & Medicaid Services (CMS) at a scope and severity level G, meaning actual harm occurred but the situation was no longer at the Immediate Jeopardy level. The acceptable IJRP included the following summarized actions: 1. On [DATE] Resident 1 eloped and did not return to the facility. Resident 1 died on [DATE]. 2. On [DATE], the Registered Nursing Consultant (RNC) immediately in-serviced (educate) the DON on monitoring and supervising residents for safety and elopement, Dementia Care, Supervision of Dementia Residents, and Elopement and wandering. 3. On [DATE] and [DATE], the DON immediately placed six (6) residents (Residents 6, 7, 8, 9,10, and 11) identified as at risk for elopement/wandering and on thirty-minute rounding (monitoring/supervising) until reassessments were completed and care plans were fully updated. The intervention of close monitoring was removed from Residents 6, 7, 8, 9 ,10, and 11 care plans and thirty-minute rounding was added to the care plans. 4. On [DATE] and [DATE], the Medical Record Director (MRD), and the RNC, immediately reviewed and audited the care plans for Residents 6, 7, 8, 9 ,10, and 11 at risk of elopement/wandering to verify that interventions were current, updated and revised, individualized, and reflected the resident's current behavior status. 5. On [DATE] and [DATE], the Interdisciplinary Team (IDT- a collaborative group of professionals from diverse fields such as doctors, nurses, therapists, and social workers who work together, sharing expertise to provide comprehensive, integrated care for a patient's complex physical and psychological needs), Director of Staff Development (DSD) Consultant and RNC, immediately completed individualized Wandering and Elopement Risk Assessments for Residents 6, 7, 8, 9 ,10, and 11 who were at risk for elopement/wandering. 6. On [DATE] at 10 a.m., a contracted vendor installed alarms at Gates 4, 5, 6, and 7 [[NAME] Street Gate (Gate 4), [NAME] gate to side yard (Gate 5), Gate to side yard (Gate 6), and [NAME] Street Gate (Gate 7)]. On [DATE] at 4:30p.m., the contracted vendor tested and verified that all four gate alarms were fully operational. 7. On [DATE] and [DATE], the RNC immediately notified all attending physicians for Residents 6, 7, 8, 9, 10, and 11, who were identified as being at risk for elopement/wandering, to obtain updated physician orders supporting the revised care plan interventions listed above. During the same period, the RNC and the DSD Consultant conducted in-service training for two Certified Nursing Assistants (CNAs), one Registered Nurse Supervisor (RN), and one Licensed Vocational Nurse (LVN). The training covered: (a) elopement prevention and intervention techniques; (b) proper use and documentation of close monitoring procedures; (c) strategies for deˆescalating exitˆseeking behavior; and (d) immediate reporting requirements when resident behaviors escalate (someone's actions or emotions start small but slowly get stronger or more intense). 9. On [DATE] and [DATE] Nurse Consultant and DSD Consultant educated 64 Licensed Nurses, Certified Nursing Assistants and Nursing supervisors on their duty to escalate unresolved behavioral risks to the care plan team, DON, ADMIN, and physician. 10. On [DATE] at 10 a.m., all facility elopement alert systems were audited by Maintenance Consultant and [NAME] President of Construction and Physical Plant (VP). The following systems were audited with the following:a. Wander Guard Door Alarms (are electronic security systems designed for healthcare and senior living facilities to prevent residents with Alzheimer's, dementia, or cognitive impairments from wandering away from safe areas) were labeled and checked for functionality for the six (6) doors [Door #1 (Lobby Door), Door #2 (Stairwell), Door #3 (Emergency Exit 1), Door # 4 (Emergency Exit 2), Door #5 (Activity/Dining room), and Door #6 (Emergency Exit 3)] b. Maintenance consultant and VP labeled perimeter gates along with matching interior facility alarm that sounds when the gate is opened. The following four (4) perimeter gates and alarm were tested for functionality and passed [[NAME] Street Gate (Gate 4), [NAME] gate to side yard (Gate 5), Gate to side yard (Gate 6), and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	[NAME] Street Gate (Gate 7)] c. A facility-wide environmental safety audit was completed by Maintenance Consultant and VP of all exits, stairwells, and common areas. Seven (7) Exit doors (Front Door, Stairwell, Elevator, Kitchen Back Door, Rehab Room back door, Medical Records back gate, and Garage Gate /pedestrian door) were audited for working alarms and appropriate signage (e.g., STOP signs, visual barriers) all passed the audit. d. Each alarm was labeled and tested with the gate number it is assigned by the VP with the following findings. Staff were able to respond within one minute. The perimeter gates are locked but can be pushed open for emergency egress. e. Sliding door stoppers were installed on sliding doors in resident rooms and inspected by maintenance consultant and VP. 12. On [DATE] at 2 p.m., door alarms were installed and inspected on all exterior facing sliding doors in resident rooms that access patios and/or balconies by maintenance consultant and The sliding door stoppers with reinforcements and visual cues for residents to prevent elopement. The facility staff are able to remove the door stoppers in the event of an emergency. The sliding doors are not emergency evacuation exits and will not prohibit exit in case of an emergency. 13. On [DATE] at 2:30 PM, stoppers and alarms were installed on facility windows by maintenance consultant. 14. On [DATE] at 3 PM, resident rooms (Rooms 1, 2, 3, 4, 5, and 6) for identified higher risk elopement residents were audited by VP with the following findings: a. room [ROOM NUMBER]: Metal stopper in place for sliding door, door alarm in place and functional - no window present b. room [ROOM NUMBER]: 2 windows with metal stoppers in place (x2-twice) and alarms in place and functional (x2) - no sliding door present. c. room [ROOM NUMBER]: Metal stopper in place for sliding door, door alarm in place and functional - no window present. d. room [ROOM NUMBER]: Metal stopper in place for sliding door, door alarm in place and functional - no window present. e. room [ROOM NUMBER]: Metal stopper in place for sliding door, door alarm in place and functional - no window present. f. room [ROOM NUMBER]: Metal stopper in place for sliding door, door alarm in place and functional - no window present. 15. On [DATE], the RNC updated the facility's policy and procedures on elopement prevention, risk identification upon admission, and escalation procedures to include H. If the resident does not return safely the facility will call surrounding hospitals, notify the RP and Medical Doctor (MD-physician) search the area and etc. and Staff will upload the residents photo upon admission to our Electronic Medical Records and Document if resident refuses to take a photo at the facility during admission and readmission. Sixty-four (64) Nursing Staff were in-serviced on the updated Elopement and Wandering Policy and Procedure. Findings: A review of Resident 1's General Acute Care Hospital (GACH 1) Psychiatry (A field of medicine that focuses on understanding, diagnosing, and treating mental, emotional, and behavioral disorders) Consult Note dated [DATE], indicated that Resident 1 was admitted to GACH 1 on [DATE] for decreased oral intake and unintentional weight loss. The psychiatric consultation was requested due to the resident's increased confusion. The consultation notes further indicated that Resident 1 lacked capacity to make medical decisions. The psychiatry consultants noted that Resident 1 had a one-to-one sitter (1:1 - a staff member or trained companion assigned to provide continuous bedside supervision to ensure the patient's immediate safety). The consultants documented that Resident 1 appeared confused and was alert and oriented only to name/self (oriented x1). They also noted that Resident 1 required constant redirection due to frequent attempts to get out of bed. A review of Resident 1's admission record indicated that Resident 1 was admitted to the facility on [DATE] with diagnoses including acute kidney failure (the sudden loss of kidney function that impairs the ability to filter waste, balance fluids, and regulate electrolytes), cirrhosis of the liver (lateˆstage, often irreversible scarring of liver tissue), dementia (a decline in cognitive functioning -memory, language, problemˆsolving, and thinking that interferes with daily life), anxiety (excessive and persistent worry or fear that disrupts functioning), proteinˆcalorie malnutrition (a deficiency of essential macronutrients needed to meet the body's requirements), restlessness (excessive, nonˆpurposeful movement or pacing), and agitation (including verbal aggression). A review of Resident 1's Change in Condition (COC - is a sudden or significant deviation from a patient's baseline physical, cognitive, or functional status. It signifies an acute deterioration or improvement (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	requiring intervention) form dated [DATE] at 10:02 a.m. showed that Resident 1 was identified as an elopement risk starting that morning. Resident 1 was alert and oriented to one area, newly admitted on [DATE], verbally responsive, and able to walk without assistance. The resident was observed to be anxious and frequently wanting to leave the facility. A review of Resident 1's Wandering & Elopement Risk Assessment, dated [DATE] at 10:10 AM, indicated that Resident 1 had not eloped but was assessed as a moderate elopement risk under section D due to recent observable wandering that was not easily ended or redirected. However, under section G on Wandering & Elopement Assessment Risk Score indicated Resident 1 was a Low Probable Risk for elopement. A review of Resident 1's Physician Progress Note dated [DATE] at 1:23 p.m. showed that Resident 1 had increasing confusion, agitation, and significant dementia. The note stated that Resident 1 primary language is not English, appeared confused, could not participate in a goalˆdirected conversation, and appeared disorganized. The physician documented that Resident 1 could not make needs known and did not have the mental capacity to make medical decisions. A review of Resident 1's Elopement Risk/Wanderer Care Plan (CP), initiated on [DATE], indicated that Resident 1 was at risk for wandering due to exitˆseeking behavior, new admission status, and verbalizations of wanting to leave the facility. The care plan goals included ensuring that Resident 1 did not leave the facility unattended and that the facility maintained the resident's safety. Interventions included addressing the resident's wandering behavior by walking with the resident or attempting to redirect the resident from inappropriate behaviors, as well as evaluating the resident for the need for additional supervision and providing close monitoring. A review of Resident 1's facility Order Summary Report for [DATE] indicated the following physician orders:On [DATE], monitoring of the Wanderguard (an electronic safety device worn as a bracelet or anklet to help prevent residents with cognitive impairment from wandering or eloping) on the right ankle every shift.On [DATE], monitoring of the Wanderguard's functionality every shift using a tester. A review of Resident 1's Nurses Notes dated [DATE] at 9:44 p.m. indicated that Resident 1 was ambulatory (to walk) and required limited assistance with activities of daily living (ADLs, such as bathing, dressing, and toileting) during this shift. The progress notes documented multiple episodes (number not specified) of wandering, and a Wanderguard was placed on the resident's right ankle. The notes further indicated that Resident 1 had several episodes of agitation (number not specified) during the 3 p.m. to 11 p.m. shift, characterized by attempts to hit staff during efforts to redirect the resident back to the room when the resident was attempting to exit the facility. The RN was notified. 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 [DATE] at 9:44 p.m. indicated that Resident 1 was restless, pacing, grimacing, which was documented as a new change in behavior. The SBAR noted that the physician was informed, no new orders were received, and no additional interventions were documented. A review of Resident 1's Nurses Notes dated [DATE] at 11:09 p.m. indicated that Resident 1 displayed multiple episodes of wandering (number not specified) during the 3 p.m. to 11 p.m. shift and attempted to elope from the facility. The note further indicated that the registered nurse supervisor was made aware of the situation, and no new interventions were received at that time. A review of Resident 1's Medication Administration Record (MAR) for [DATE] indicated that on [DATE], during the day shift (7 a.m. to 3 p.m.), the resident manifested five episodes of anxiety-related behaviors manifested by (m/b) agitation. The MAR further indicated that the resident exhibited an additional five episodes of anxiety-related behaviors during the evening shift (3 p.m. to 11 p.m.). The MAR further indicated, by check mark, that Resident 1 exhibited wandering behavior during the 3 p.m. to 11 p.m. shift. A review of Resident 1's COC dated [DATE] at 8:44 a.m. indicated that the resident was identified as an elopement case that morning. The Medication Nurse reported that Resident 1 could not be found in his room. All staff searched for the entire facility but were unable to locate the resident. The facility called 911, and a missing person report was filed with the Los Angeles Police Department (LAPD). A review of Resident 1's Nurses Notes dated [DATE] at 10:57 a.m. indicated that the resident had been (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	very agitated during the previous overnight shift (11 p.m. to 7 a.m.) and repeatedly expressed a desire to go home. On [DATE] at approximately 7:40 a.m., a certified nursing assistant (CNA) assisted Resident 1 by setting up breakfast in the resident's room. At around 7:50 a.m., a Restorative Nursing Assistant (RNA, an advanced certified nursing assistant who provides specialized rehabilitative care), reported seeing Resident 1 sitting on the bed. At approximately 8:20 a.m., a charge nurse entered Resident 1's room to administer medications and observed that the resident was not present. The sliding door in Resident 1's room was found open. Facility staff immediately initiated a search of the building and surrounding areas, including all resident rooms, restrooms, the backyard, and the garage. The notes indicated that Closed-Circuit Television (CCTV, a video surveillance system) footage was reviewed; however, Resident 1 was not seen existing through the main entrance or any other door. The same Resident 1's Nurses Notes indicated Resident 1's family member (FM 1) was notified. FM 1 reported that Resident 1 had expressed a desire to go home on the previous day ([DATE]) and confirmed that the resident had significant memory impairment and was very confused. Emergency services and law enforcement were notified to file a missing person report. Resident 1's attending physician was also informed of the situation. The Nurses Notes concluded with: At the time of this report, all staff members continued to search for the resident. A review of the Los Angeles Fire Department (LAFD) Patient Care Report dated [DATE] at 12:02 a.m. showed that Emergency Medical Services (EMS- It is a comprehensive system providing out-of-hospital, acute medical care and transportation for victims of sudden illness or injury) arrived on scene at 12:09 a.m. and found Resident 1 lying on the street with police present. EMS could not identify the resident or locate any identification. Resident 1 had second (partial-thickness burn) damages the outer layer (epidermis) and part of the underlying layer (dermis) of the skin, causing severe pain, redness, swelling, and blistering) and third-degree (is a severe medical emergency that destroys all layers of the skin-the epidermis and dermis-and can damage underlying fat, muscle, and bone) burns on the neck, face, shoulders, and back. Police suspected that a substance had been thrown on the resident and the resident had been set on fire. EMS noted that the resident's airway (the pathway that allows air to travel in and out of the lungs for respiration) was compromised, with swelling and burn injuries. Resident 1 was hot to the touch, unresponsive, and had labored breathing. EMS assisted breathing with a Bag-Valve-Mask (BMV-a handheld medical device used in emergency care to provide positive pressure ventilation (PPV-a technique where a machine (ventilator) forces air into the lungs to assist or replace breathing) to patients who are not breathing or breathing inadequately) and inserted an oropharyngeal airway (is a curved, rigid, plastic, or rubber medical device inserted into the mouth of an unconscious or unresponsive patient). An intraosseous (IO- inside a bone) line (access - is a medical technique used in emergencies to deliver fluids and medications directly into the marrow of a bone) was placed in the left lower leg, and 500 milliliters (mL) of normal saline (NS- is a sterile solution used widely in clinical settings for intravenous (IV-inside a vein) hydration, wound irrigation, and drug dilution). The cause of injury was documented as burn/chemical/fire exposure. After interventions, EMS transported the resident to the nearest trauma center (GACH 2) due to airway compromise (obstruction/any blockage (foreign body, swelling, or trauma) preventing air from entering or leaving the lungs) and paramedic judgment. A review of Resident 1's GACH 2 Emergency Department physician notes dated [DATE] at 12:56 a.m. indicated the following: Resident 1 arrived with severe burn injuries. The onset was estimated to be about one hour prior. Burns were located on the face, back, circumferential neck, and shoulders, with swelling, redness, and loss of mobility. The resident had a bracelet from the convalescent facility on the left wrist. Symptoms were severe and worsening, with smoke inhalation, shortness of breath, and altered mental status. The incident occurred in the street. Paramedics (a highly trained allied health professionals who provides advanced, prehospital emergency medical care, stabilization, and transportation for critical patients) reported they found Resident 1 unconscious on the roadside with burns to the neck, shoulders, face, scalp, and back. They placed an oral airway (a device used to maintain an open, unobstructed airway (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	in unconscious patients)_ and assisted breathing (The therapeutic process uses a machine (ventilator or respirator) to help move air into and out of the lungs when a patient cannot breathe adequately on their own). The scalp had widespread partialˆthickness burns (damage the epidermis, and part of the dermis, causing blisters, intense pain, swelling, and moist, red skin), hair was singed (hair that has been superficially or lightly burned, scorched), and the face and tongue were swollen. EMS was unable to obtain intravenous (IV - inside a vein) access and placed an intraosseous (IO- administered by entering a bone) line in the right lower leg before transporting the resident to the hospital. The emergency department physician at GACH 2 documented that Resident 1 had 35% total body surface area burns: 25% secondˆdegree burns (partialˆthickness injuries damaging the outer layer of skin and part of the underlying layer, causing intense pain, swelling, redness, and blistering) and 10% thirdˆdegree burns (fullˆthickness injuries destroying both skin layers; these burns may be painless due to nerve damage). The entire back was blackened with partial-thickness burns. Due to swelling and airway compromise, the resident required an escharotomy (an emergency surgical procedure involving incisions through thick, leathery burn tissue to relieve pressure) of the neck by trauma surgery and was intubated (having a tube inserted into the body, most commonly the trachea (windpipe), to maintain an open airway and support breathing, typically via a ventilator during surgery, emergency, or critical illness). Four liters of lactated Ringers (LR - fluid used for hydration and resuscitation [is the emergency medical process of reviving a person from apparent death, unconsciousness, or correcting acute physiological failures (sudden, life-threatening deteriorations in body function where an organ or system can no longer maintain normal homeostasis, demanding immediate medical intervention to prevent death), such as stopped breathing or heart function]) were given for burn resuscitation (the critical time -sensitive treatment used to manage severe burn injuries by replacing lost fluids). After intubation and escharotomy, the physician arranged transfer to a burn center (GACH 3). Air ambulance was contacted with a 10-minute estimated arrival time. The physician documented providing 65 minutes of critical care. A review of Resident 1's the facility Nurses Notes dated [DATE] at 1:15 p.m. indicated that a Registered Nurse Supervisor (RN) received a telephone call from a unit coordinator at GACH 2, who reported that Resident 1 had been found in a burned building. A review of Resident 1's the facility Nurses Notes dated [DATE] at 4:53 p.m. indicated that GACH 3 contacted the facility and informed staff that Resident 1 had expired at GACH 3 on [DATE] at 9:45 a.m. During an interview on [DATE] at 10:50 a.m., the DON stated that Resident 1 was last seen by RNA 1 inside the resident's room on [DATE] at 7:50 a.m., during breakfast time. The DON stated that LVN 1 discovered Resident 1 missing at approximately 8:15 a.m. on [DATE], when LVN 1 entered the resident's room to administer medications. The DON further stated she received a call on [DATE] at approximately 12 a.m. (midnight) from RN 3, who informed her that RN 3 had received a call from GACH 2 requesting that Resident 1's face sheet be electronically sent because the resident was going to be transferred to GACH 3. During an interview on [DATE] at 12:43 p.m., LVN 1 stated that on [DATE] at approximately 8:10 a.m. to 8:15 a.m., he (LVN 1) was standing near the entrance of Resident 1's room preparing medications to administer to the resident. LVN 1 stated that when he entered the room to speak with Resident 1 before administering the medications, the resident was not inside the room or in the bathroom located within the room. LVN 1 stated he observed that the balcony sliding door and screen door in Resident 1's room were slightly ajar. LVN 1 reported that he immediately notified RN 2 and the desk nurse, LVN 2, and that RN 2 initiated Code 11 (an emergency procedure used when a resident is missing from their assigned location). LVN 1 stated that Resident 1 was new to the facility and spoke only his native language. On the same interview, LVN 1 stated that during the 7 a.m. to 3 p.m. shift on [DATE], Resident 1 had been pacing back and forth in the hallways looking for exits from the facility. According to LVN 1, the resident appeared agitated, frustrated, and repeatedly verbalized a desire to leave while attempting to exit the facility multiple times (numbers not specified). LVN 1 stated that Resident 1 unsuccessfully attempted to leave through the front lobby reception exit door, the laundry room exit door, and the kitchen area exit (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056321	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Convalescent Hospital	1100 S. Alvarado St Los Angeles, CA 90006

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	door. LVN 1 further stated that due to the resident's exit-seeking behavior, a Wanderguard device was placed on Resident 1's ankle. During an interview on [DATE] at 12:47 p.m., Registered Nurse Supervisor (RN) 2 stated that the facility first identified Resident 1 as an elopement risk on [DATE] after the resident stated that he wanted to go home. RN 2 further stated that on that date, the facility determined that Resident 1 required a Wanderguard. RN 2 stated that several CNAs (names not recalled) and an RNA (name not recalled) monitored Resident 1 on a oneˆtoˆone (1:1) basis during the morning and after breakfast. RN 2 stated that the 1:1 monitoring was discontinued after the Wanderguard device was applied to Resident 1 on [DATE] morning. RN 2 also stated that the sliding doors in Resident 1's room did not have alarms connected to the Wanderguard system (is a specialized electronic security solution used in hospitals, nursing homes, and memory care facilities to prevent residents with cognitive impairments from wandering away from safe areas) and therefore would not alert staff if the resident attempted to exit through that door. RN 2 further stated that no alarms sounded to alert staff when Resident 1 eloped on [DATE]. During a phone interview on [DATE] at 2:14 p.m., Registered Nurse Supervisor (RN) 1 stated she received report from GACH 1 on [DATE] regarding Resident 1, and GACH 1 informed her that the resident was an elopement risk. RN 1 stated that Resident 1 walked very well without a mobility device and liked to wander around the facility. She stated that Resident 1 would enter other residents' rooms and sit in a chair next to their beds. RN 1 stated that at some point on [DATE], Resident 1 exited through the back door onto the facility's patio, and a CNA brought the resident back inside. RN 1 further stated that on another occasion on that day ([DATE], time not recalled), Resident 1 exited the facility, and she and another nurse (name not recalled) brought the resident back inside. RN 1 also stated she contacted Family Member (FM) 1 and asked whether FM 1 or another family member could come to the facility to stay with Resident 1 due to the resident's agitation. During an observation and interview on [DATE] at 2:17 p.m. with Maintenance Supervisor (MS) 1, MS 1 stated that Resident Rooms 126, 128, 130, 132, 134, 136, and 138 had sliding doors and screens that did not have alarms and provided access to the outside patio located at the back of the facility. MS 1 stated that the facility's outside patio had two exits leading to two public streets, [NAME] Avenue and [NAME] Street. MS 1 further stated that the two gates leading from the patio could be opened from the inside but not from the outside. During an interview on [DATE] at 2:47 p.m., RN 3 stated that on [DATE] (time not recalled), she received a call from GACH 2 informing her that an unidentified individual had found Resident 1 on a street (name of street not recalled). RN 3 stated that GACH 2 requested that Resident 1's face sheet and order summary be faxed to them. RN 3 further stated that GACH 2 informed her that Resident 1 would be transferred to GACH 3 because the resident had sustained burns. During an interview on [DATE] at 9:41 a.m., CNA 1 stated he had heard from staff (unable to recall who) that Resident 1 was ambulatory and had an elopement risk. CNA 1 stated that on [DATE] morning, no CNA was assigned specifically to monitor Resident 1 for safety or to prevent wandering or elopement. CNA 1 stated that RN 2 instructed him to check on Resident 1. CNA 1 reported that he went to the resident's room and observed Resident 1 ambulating inside the room. CNA 1 stated he asked Resident 1 to sit on the bed and then brought the resident's breakfast tray, placing it on the bedside table. CNA 1 stated he left Resident 1 seated on the bed and was away from the room for about 10 minutes. When he returned, Resident 1 was standing in the room. CNA 1 stated the resident went into the restroom and changed clothes, switching from short pants to long pants. CNA 1 stated he directed Resident 1 to sit back on the bed and encouraged him to eat breakfast, noting that the resident appeared fine and smiled at him. CNA 1 stated that the last time he saw Resident 1 was at 7:50 a.m., on [DATE]. CNA 1 further stated that he then proceeded to attend the facility's staff huddle (A quick, informal meeting where people gather closely to share updates or plan something) at Nursing Station 1 at approximately 8:15 a.m. on [DATE], and that the huddle lasted about 20 minutes. During an interview on [DATE] at 10:27 a.m., CNA 2 stated that she ar[TRUNCATED]