STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555004	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Playa Del Rey Center	7716 Manchester Avenue Playa Del Rey, CA 90293

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 follow the facility's policy and procedure for Out On Pass for one of three sampled residents (Resident 1) when Resident 1 left the facility without being assessed, someone accompanying him, and signing out in the Out on Pass log.This deficient practice has the potential for Resident 1 to be injured while outside the facility's premises without the facility's knowledge. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body), aphasia (a disorder that makes it difficult to speak), and difficulty in walking.During a review of Resident 1's History and Physical (H&P) dated 5/18/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 1 usually understood others and was able to sometimes be understood. The MDS indicated Resident 1's cognition (process of thinking) was intact. The MDS indicated Resident 1 was independent from staff with eating but required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff for bathing. The MDS indicated Resident 1 was independent from staff for rolling left and right and required set up assistance (helper assists only prior to or following the activity) from staff for bed to chair transfer and for wheeling 50 feet in a manual wheelchair.During a review of Resident 1's progress notes, dated 3/31/2026, the progress notes indicated on 3/31/2026 at 1:24 a.m. and at 1:45 a.m., a message was left for Resident 1's physician when Resident 1 did not return from being out on pass.During an interview on 4/1/2026 at 2:30 pm with Administrative Assistant (AA1), the AA1 stated she sits at the front desk to greet visitors and ensure they sign in before entering the facility. The AA1 stated the residents would sign out at the nursing station before going out on pass. The AA1 stated she did not see Resident 1 leave the facility on 3/30/2026.During an interview on 4/1/2026 at 2:36 pm with Resident 2, Resident 2 stated he was roommates with Resident 1 for a couple of weeks, and Resident 1 told him it was time for Resident 1 to leave because he had been in the facility long enough.During a concurrent interview and record review on 4/1/2026 at 2:57 pm with Licensed Vocational Nurse (LVN) 1, Resident 1's progress notes, dated 3/30/2026, and physician order, dated 1/6/2026, were reviewed. The progress notes indicated assessments were not done for Resident 1 before Resident 1 left the facility. The physician order indicated Resident 1 may go out on pass (OOP) for two to four hours accompanied. LVN 1 stated residents were supposed to inform the nurse before leaving the facility so a skin assessment could be done. LVN 1 stated when the residents return to the facility, a full assessment would be done. LVN 1 stated Resident 1's order indicated he needed someone to accompany him when leaving the facility and if Resident 1 left the facility alone, his safety would be compromised, and he could get hurt in the streets.During an interview on 4/1/2026 at 4:25 pm with the Activities Assistant (AA2), the AA2 stated that she saw Resident 1 at the bus stop across the street from the facility when she was driving back after lunch around 12:00 pm. The AA2 stated she did not see (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
	555004	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Playa Del Rey Center	7716 Manchester Avenue Playa Del Rey, CA 90293

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	anyone with him and did not report it because he goes outside a lot.During a concurrent interview and record review on 4/1/2026 at 4:47 pm with the Director of Nursing (DON), the facility's document Resident Out On Pass Log was reviewed. The log had entries dated from 3/29/2026 through 4/1/2026 and did not have an entry on 3/30/2026 for Resident 1 leaving the facility. The DON stated the log is kept at nursing station 1 near the front door and should be completed when residents leave and return to the facility. The DON stated Resident 1 was aware that he needed to sign out and leave with someone but Resident 1 did not sign the log on 3/30/2026.During a review of the facility's policy and procedure (P&P), Out On Pass dated 8/25/2021, the P&P indicated prior to the resident leaving on pass, a Licensed Nurse would assess the resident's physical and mental status and document the time the resident left the facility, the name of the accompanying responsible person, the destination, a contact phone number, and expected time of return.