STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555039	A. Building B. Wing	03/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fireside Health Care Center	947 3rd Street Santa Monica, CA 90403

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** 45528 Based on observation, interview, and record review, for one of three sampled residents (Resident 1), facility failed to: 1. Monitored and supervised Resident 1 to prevent elopement (the act of leaving a facility unsupervised and without prior authorization). 2. Ensure the alarm system was functioning on two of five exits doors (Door C- [south side exit door leading to the front of the facility] and Door E [northside door, at the back of the facility leading to the alley]) to alert staff if a resident was eloping and or exiting the facility. 3. Ensure the alarm system was activated/functional on one of five exit doors (Door D- northside back of the facility exit door leading to the side street). 4. Ensure that the alarm system was checked for proper functionality for five of five exit doors. 5. Ensure that Resident 1's care plan was resident specific for possible elopement. These deficient practices resulted in Resident 1 eloping from the facility on 2/27/2025, at 1:40 P.M., placing the resident at increased risk for extreme weather conditions, medical emergencies, accidents, injuries, hospitalization , and/or death. Findings: During a record review, Resident 1's Admission Record indicated the facility admitted Resident 1 on 1/10/2025 with diagnoses including epilepsy (a brain disorder that causes seizure which are abnormal electrical surges in the brain), cardiac pacemaker (a small battery powered device that prevents the heart from beating too slowly), and hypertension (HTN - elevated blood pressure). During a record review, Resident 1's care plan date initiated 1/14/2025, indicated Resident 1 had a history of ETOH (ethyl alcohol -a type of alcohol found on alcoholic beverages) abuse and withdrawal. (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 record review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/17/2025, indicated Resident 1 was cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 1 required substantial/maximal staff assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review, Resident 1's physician orders dated 1/10/2025 indicated that Resident 1 may go out on pass with responsible party for therapeutic purposes. During a record review, Resident 1's Situation, Background, Assessment, Recommendation (SBAR - situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 2/27/2025 indicated the Infection Preventionist Nurse (IPN) documented that on 2/27/2025 at 1:10 P.M., Certified Nursing Assistant (CNA) 1 saw Resident 1 in the facility lobby. The SBAR indicated that on 2/27/2025 at 1:55 P.M., CNA 1 informed LVN 1 that Resident 1 was out of the facility and LVN 1 then alerted an unidentified facility staff. LVN 1 and the other checked the vicinity and when they could not find Resident 1, LVN 1 and the facility staff went outside the building (facility) and asked the [NAME] (VT) staff if VT had seen Resident 1. The SBAR indicated VT stated that on 2/27/2025 at 1:40 P.M., [NAME] staff (use identifier) saw Resident 1 walking towards the street by the facility and was heading towards the nearby stores. The SBAR also indicated that facility staff (unidentified) checked nearby streets and stores, however, Resident 1's was nowhere to be found. The SBAR indicated the facility also called Resident 1's phone number which went to voicemail. An unidentified facility staff also called Resident 1's family member (FM) emergency contact who said that FM did not know where Resident 1 was. The SBAR further indicated that facility staff called the police, the nearby hospitals and were told that Resident 1 was not with the police or the nearby hospitals. The SBAR further indicated that the facility staff will continue to search for Resident 1. During a record review, Resident 1's Nursing Progress Notes dated 2/28/2025 at 6:48 A.M., indicated, Licensed Vocation Nurse (LVN) 2 documented that on 2/28/2025 at 12 A.M., a staff (unknown) notified the facility that on the way home staff spotted Resident 1 on the street a few blocks away from the facility. The Nursing progress note further indicated that unidentified two staff members went to bring Resident 1 back to the facility. During a record review, Resident 1's Physician's Orders dated 2/28/2025, indicated a physician ordered STAT (STAT -immediate) CBC (CBC -comprehensive blood count [blood work that checks for different types and numbers of cells in the blood]), CMP (CMP -comprehensive metabolic panel [blood test that measures proteins, enzymes, electrolytes, minerals and other substances in the body]) and alcohol levels. During an interview on 2/28/2025, at 2:50 P.M., Resident 1 stated that on 2/27/2025 (unable to remember the time), Resident 1 sneaked out through the main door in the facility lobby. Resident 1 stated they was a crowd of people in the lobby and that is when Resident 1 sneaked out of the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/2025, at 3:34 P.M., CNA1 stated CNA 1 last saw Resident 1 on 2/27/2025 at around 1:15 P.M. maybe 1:20 P.M., and that Resident 1 told CNA 1 that Resident 1 was going to the lobby area for a change of scenery (how the place looks). CNA 1 stated that on 2/27/2025 at around 1:30 P.M. maybe 1:40 P.M, CNA 1 went to look for Resident 1 and was not able to find Resident 1 in the facility and immediately notified LVN 1 that Resident 1 was missing. During an interview on 2/28/2025, at 3:57 P.M., LVN 1 stated LVN 1 last saw Resident 1 in his room on 2/27/2025 at around 12 P.M. maybe 1 P.M, during medication pass/administration. LVN 1 stated that on 2/27/2025 at around 1:30 P.M., CNA 1 reported to LVN 1 that Resident 1 was gone, and could not be found. LVN 1 further stated that LVN 1, CNA 1, and other facility staff looked for Resident 1 inside the entire facility and outside the facility but were not able to find Resident 1. LVN 1 stated facility staff including the Facility Administrator (FA) asked the if VT had seen Resident 1. The VT said that on 2/27/2025, at 1:40 P.M., VT saw Resident 1 walking towards the street in front of the facility and was heading towards the nearby stores. LVN 1 stated the facility staff said it had been five minutes maybe seven minutes since the VT last saw Resident 1. LVN 1 stated the VT did not alert/notify LVN 1 that Resident 1 had left the facility building. LVN 1 stated facility staff including LVN 1 searched the surround neighborhood, called nearby hospitals and called Resident 1's phone but Resident 1 was nowhere to be found. LVN 1 stated LVN 1 went home at around 3:50 P.M. maybe 4 P.M., but Resident 1 had not been found. LVN 1 stated that on 2/27/2025, a staff member (unknown) found Resident 1 at a nearby store and called the facility. During a telephone interview on 3/1/2025, at 10:55 A.M., Receptionist (RP) 1 stated RP 1 worked on 2/27/2025. RP 1 stated that on 2/27/2025 at around 2 P.M. maybe 2:30 P.M., LVN 1 informed RP 1 that Resident 1 was not in the facility. RP 1 stated on 2/27/2025 RP 1 went on a lunch break and returned between 12:10 P.M., and 12;15 P.M., and did not see Resident 1 leave the facility. RP 1 stated RP 1 was not sure what RP 1 was doing when Resident 1 was reported missing or having left the facility. RP 1 stated RP 1 may have been assisting another resident, taking a telephone message, or answering the phone. RP 1 stated RP 1 may have gone to a nursing station to deliver a telephone note because the facility staff do not answer the phones when she calls the nursing stations which happens a lot. RP 1 stated RP 1 will leave the front desk without any coverage to deliver the notes to the nursing stations. During a concurrent observation of the facility five exit doors and interview on 3/1/2025, at 12:57 P.M., with the Facility Administrator (FA) and the Registered Nurse Supervisor (RNS), the facility following exit doors did not alarm on exit: 1. Exit door (Door B) on the southside leading to the front of the facility, 2. Exit door (Door D) on the southside of the facility leading to the side street to the facility, 3. Exit door (Door E) on the northside of the facility leading to the back alley (door E). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The FA stated Door B has an alarm system that needs to ring when pushed, however, when FA pushed the Door B open, the door opened but did not alarm. FA stated Door B should alarm when pushed open so that when a resident is leaving the facility, facility staff is/are alerted. FA stated failure for the door to alarm when pushed open makes that door a safety risk that can lead to residents wandering, falling, and suffer hypothermia with the cold weather at night. FA stated the exit Door D did not have an alarm system on the door because resident use the small patio by the door to smoke. FA stated there is a small gate that is about two and half feet (ft -unit of length measure) maybe three ft tall and a person that is tall enough may be able to hop over the gate and wander off. RNS stated Door E has an alarm system on the door, however, when the surveyor and RNS pushed the door open, the door did not alarm. RNS stated Inservice for door not alarming was going to be provided to the staff because Door E was not locked, and the alarm was off/not on. RNS stated Door E leads to the alley in the back of the facility and that the door needs to be closed and alarm is on at all times to avoid residents from going out the facility without supervision. RNS stated residents may wander, get lost, get hurt, fall, or get hit by a car. During a record review, the facility 5-Day Summary undated report, indicated that on 2/27/2025 at around 11:30 P.M., a staff (unidentified) spotted Resident 1 at two blocks from the facility and notified the facility. Two staff members brought Resident 1 back to the facility . The 5-Day Summary report indicated In-services for elopement, door alarms and resident safety started on 2/28/2025 . Logs for door alarm checks created and will be kept daily. During a concurrent interview and record review, on 3/1/2025, at 1:55 P.M., with RNS, Resident 1's medical chart was reviewed. The RNS stated the facility process is that immediately on an admission, the Registered Nurse conducts a standalone elopement assessment on every resident and also to assess the residents' current health conditions or diagnosis history that may place a resident to be at risk for elopement. RNS stated the facility did not complete/conduct elopement assessment for Resident 1 on admission, 1/10/2025. RNS stated elopement assessment was completed only after Resident 1 eloped on 2/27/2024. RNS stated Resident 1 had a history of ETOH abuse withdrawal which could pose as a risk factor for Resident 1 to elope from the facility because of craving alcohol. RNS stated Resident 1 should have been monitored closely for possible elopement which was not included in Resident 1's care plan. During an interview on 3/1/2025, at 2:40 P.M., FA stated facility does not have any documented evidence that indicated when the facility checked if the five exits door alarms were functional/operational. FA stated the facility should have a log to show that the exit door alarms are in proper working condition. FA stated if the exit doors do not alarm and or not working condition, could result in residents leaving the facility without staff being aware. During a record review if the facility's policy and procedure (P&P), titled, Door Alarm System, revised 10/16/2024, indicated, the skilled nursing facility will maintain a fully functional alarm system to enhance resident safety and prevent unauthorized exits. Procedure: 1. System Maintenance and Testing a. The door alarm system will be tested daily to ensure functionality. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Any malfunctioning alarms must be reported immediately to the maintenance department for repair. 3. Resident Safety and Supervision b. Staff must ensure that all exit doors are monitored, and alarms are on at all times Compliance: Failure to adhere to this policy may result in disciplinary action in accordance with facility regulations. Regular audits will be conducted to ensure compliance and effectiveness of the door alarm system. During a record review, the facility P&P, titled, Maintenance Services, revised 10/16/2024, indicated: 1. The Maintenance Department is responsible for maintaining the buildings, grounds and equipment in a safe and operable manner at all times 8. The Maintenance Department is responsible for maintaining the following reports a. Inspection of building. During a record review, the facility P&P, titled, Wandering and elopement, revised 10/2024, 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. 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.