STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555057	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Flores Convalescent Hospital	14165 Purche Ave. Gardena, CA 90249

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. (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
	555057	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Flores Convalescent Hospital	14165 Purche Ave. Gardena, CA 90249

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide close supervision for two of seven sampled residents (Resident 1 and Resident 2) reviewed for elopement (the act of leaving a facility unsupervised and without prior authorization) risk, by failing to ensure: 1. One-to-one (1:1- a dedicated nurse assigned to continuously observe and attend to a single resident, providing close supervision and immediate interventions when needed) monitoring every shift as indicated in the care plan. 2. The functionality of the wander guard system (a technology solution designed to detect, track, and alert staff when at high risk for elopement resident attempt to exit a designated area).These deficient practices resulted in Residents 1 and 2 eloping from the facility on 7/19/2025, unsupervised for several hours, placing the residents at risk for serious harm, including injury, exposure to environmental hazards, and death. Findings: a. 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 schizophrenia (a mental illness that is characterized by disturbances in thought), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (HTN- high blood pressure), and anxiety (a feeling of fear). During a review of Resident 1's History and Physical (H&P), dated 3/2/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 6/5/2025, the MDS indicated Resident 1's cognition (process of thinking) was severely impaired. The MDS indicated Resident 1 required moderate (helper does less than half the effort) assistance from staff 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 review of Resident 1's care plan titled Resident is an elopement risk/wanderer. , initiated 5/7/2025, the care plan indicated interventions included use a wander guard bracelet and one-to-one staff monitoring on every shift to maintain the resident's safety due to elopement risk. During a review of Resident 1's Change of Condition (COC), dated 7/19/2025, timed at 11:45 a.m., the COC indicated on 7/19/2025 at approximately 10:00 a.m., Resident 1 was observed in the hallway pushing another resident (Resident 2) in a wheelchair. The COC also indicated at 11:00 a.m., during visual check rounds, the staff could not locate Resident 1 anywhere in the facility. Staff also were unable to locate the resident in the surrounding neighborhood. Resident 1 was returned to the facility on 7/19/2025 at approximately 4:45 p.m., by the Administrator (ADM). b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), anxiety, dysphagia (difficulty swallowing), and muscle weakness (loss of muscle strength). During a review of Resident 2's H&P, dated 1/30/2025, the H&P indicated Resident 2 did not have the capacity to understand and make medical decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition was severely impaired. The MDS indicated Resident 2 required moderate assistance from staff with ADLs and did not have the ability to walk. The MDS indicated Resident 2 required the use of a wheelchair for mobility. During a review of Resident 2's COC, dated 7/19/2025, timed at 11:45 a.m., the COC indicated on 7/19/2025 at approximately 10:00 a.m., Resident 2 was observed in the hallway in her wheelchair being pushed by another resident (Resident 1). The COC indicated at 11:00 a.m., the staff could not locate Resident 2 in the facility or the surrounding neighborhood. The COC indicated Resident 2 was brought back to the facility on 7/19/2025 at approximately 3:22 p.m., by a local hospital ambulance. During an interview on 7/29/2025 at 12:02 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 7/19/2025 at approximately 10:00 a.m., Resident 1 was observed in the hallway pushing Resident 2 in her wheelchair towards nurses' station near the front exit door. LVN 1 stated Resident 1 was high risk for elopement and had been issued a wander guard bracelet. LVN 1 stated Resident 1 was not on one-to-one monitoring, and instead was being checked during hourly visual rounds. LVN 1 stated Resident 2 was non-ambulatory (able to walk), used a wheelchair, and required staff assistance for mobility. LVN 1 stated at 11:00 a.m., during scheduled visual rounds check, staff were unable to locate Residents 1 and 2. LVN 1 stated she reported the missing residents to the charge nurse and staff initiated a search. LVN 1 stated she did not observe the residents exiting the facility and did not hear the front door alarm which indicated that staff were not monitoring the exit door as required to prevent residents from exiting the facility unsupervised. LVN 1 stated it was the responsibility of the Director of Staff Development (DSD) to ensure such assignments as exit monitoring were reflected in the daily staff