STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555165	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Skilled Nursing and Wellness Center	5125 Monte Vista St. Los Angeles, CA 90042

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 supervise, monitor and provide safety measures, leading to oversight of one (1) of two (2) sampled residents (Resident 1) who attempted to elope (leave the facility without the staff's knowledge and/or supervision) multiple times prior to eloping from the facility on 1/4/2026 in accordance with the facility's policy and procedure (P&P). This failure resulted in Resident 1 eloped from the facility on 1/4/2026 around 1:20 PM which placed the resident at risk for exposure to injury, serious harm, medical complications and/or death. Findings: During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with the diagnoses including but not limited to toxic encephalopathy (disease of the brain that alters brain function), depression (severe feelings on sadness and hopelessness), difficulty in walking, and lack of coordination. During a review of Resident 1's Change of Condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status), dated 1/4/2026, the record indicated Resident 1 Resident 1 eloped from the facility. The COC also indicated Resident 1 had an increase of confusion that was a persistent change from usual cognitive (ability to think and process information) function and Resident 1 had attempted to elope from the facility multiple times. The COC indicated Resident 1 was last seen at 12:30 PM on 1/4/2026 when her lunch tray was delivered at the bedside. At 1:05 PM when CNA 1 picked up Resident 1's lunch tray and noted Resident 1 was not in her room. By 1:20 PM, Resident 1 was determined missing and a code yellow (emergency operation plan) was activated. Resident was found at 3:45 PM at her apartment home and returned to the facility by caregiver and family member. During a review of Resident 1's Care Plan, dated 1/4/2026, the care plan indicated Resident 1 was at risk for decline in functional status and safety concerns during daily care tasks and at risk for decline in function status and safety concerns during daily care tasks. The staff nursing interventions were to assist the resident with activities of daily living (ADLs) as needed to promote safety and support functional ability, monitor for changes in self-performance of ADLs and report significant change to the physician, and monitor resident for fatigue, pain or safety concerns during ADL performance and intervene as needed. During a review of Resident 1's Care Plan, dated 1/4/2026, the care plan indicated Resident 1 had an episode of elopement as evidenced by history of elopement while at home, history of elopement or attempted leaving the facility without informing staff. The staff nursing interventions were to monitor resident for wandering or exit-seeking behaviors, especially during shift changes, mealtimes, and other high activity periods; educated staff to recognize triggers or patterns related to exit-seeking behavior; and notify charge nurse and interdisciplinary team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) immediately of any attempted elopement or escalation in behavior. During a review of Resident 1's Physical Therapy Notes, dated 1/5/2026, the record indicated Resident 1 was unsteady when (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	walking and unsteady when standing. The record also indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) when walking ten feet. During a review of Resident 1's Occupational Therapy Notes, dated 1/6/2026, the record indicated Resident 1's Mobility Function Score (score 0 - 12; 12 being the highest function) was 0 and safety awareness was impaired. During a review of Resident 1's History of Physical, dated 1/5/2026, the record indicated Resident 1 had intermittent ability (unpredictable or periodic loss of function) to understand and make own decisions. During an interview on 1/8/2026 at 12:32 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she last saw Resident 1 standing between Rooms A and B (Room A is next to the exit door) around 1:05 PM on 1/4/2026. During an interview on 1/8/2026 at 1:21 PM with Resident 1 in Resident 1's room, Resident 1 stated she left through the exit door and took the bus home. During an interview on 1/8/2026 at 1:49 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated normally there is a staff in the nursing station to make sure they were monitoring who goes in and out of the facility. LVN 1 stated residents who eloped could be in danger once outside of the facility and the residents could get physically harmed. During an interview on 1/8/2026 at 2:07 PM with Registered Nurse (RN), RN stated about 1:20 PM to 1:25 PM staff had informed RN that Resident 1 was not found in the facility. RN stated the gate was kept closed but staff would open the gate using a remote control at the nurses' station when visitors came to visit. RN stated the gate was opened during the time Resident 1 eloped from the facility. During an interview on 1/8/2026 at 3:36 PM with the Director of Nursing (DON), the DON stated no staff had seen Resident 1 leave the facility on 1/4/2026. The DON stated Resident 1 left through the exit door when the visitors left the facility. The DON stated staff should monitor and greet people at the entrance/exit door to prevent elopement door. During an interview on 1/8/2026 at 4:00 PM with RN, RN stated Resident 1 appeared to be more disoriented and asked questions that did not correlate in the morning on 1/4/2026. RN stated Resident 1 attempted to open the exit door and was redirected back to her room after 12:30 PM. RN stated Resident 1 tried to elope from the facility at least four (4) times prior to eloping successfully on 1/4/2026. RN stated staff had even tried to block the exit door by placing the medication cart in front of the exit door to prevent Resident 1 from eloping. RN stated that Resident 1 should have but did not have a 1:1 sitter (a dedicated caregiver or staff member assigned to continuously observe and assist a patient at high risk for falls, self-harm, or elopement) after multiple attempts to elope from the facility. RN stated he had called a huddle after Resident 1 tried to elope around 12:30 PM and informed the primary CNA (CNA 1) and other staff to be more vigilant in watching Resident 1. RN stated CNA 1 was aware that Resident 1 was trying to elope from the facility on 1/4/2026. During an interview on 1/8/2026 at 4:36 PM with CNA 1, CNA 1 stated CNA 1 could not recall RN giving a huddle in the afternoon on 1/4/2026 about Resident 1. During an interview on 1/8/2026 at 4:46 PM with CNA 3, CNA 3 stated the RN gave a huddle in the afternoon on 1/4/2026 with LVN, CNA 1, and CNA 3 and a few other staff members about Resident 1. CNA 3 stated RN stated Resident 1 was trying to go out the exit door and informed staff kept an eye on Resident 1 so she would not elope from the facility. During an interview on 1/8/2026 at 5:02 PM with the DON, the DON stated if staff knew Resident 1 was attempting to exit through the door, then the resident would be at risk for elopement. The DON stated the doctor should have been notified to get an order for a wander guard for the resident's safety. The DON stated Resident 1 should have been closely monitored by having staff visually see the resident at all times or be place on 1:1. The DON stated if these interventions were implemented this could have prevented Resident 1 from eloping. The DON stated residents could have a potential injury of resident's safety in general could be compromised when residents eloped from the facility. During a review of the facility's policy (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and procedure (P&P) titled, Wandering and Elopement, revised 1/22/2025, the policy indicated, the resident's risk for elopement and preventative interventions will be documented in the resident's medical record and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change in condition according to the RAI guidelines. The IDT will develop a plan of care considering the individual risk factors of the resident. If facility staff observes a resident leaving the premises unaccompanied or without having followed proper procedures, he/she may try to prevent the departure in a courteous manner. During a review of the facility's P&P titled, Resident Safety, revised 1/22/2025, the policy indicated the IDT will establish a person-centered observation or monitoring systems for the Resident to address the identified risk factors identified, to observe the safety and wellbeing of the Residents, a Resident check will be made at least every two hours around the clock by nursing service personnel. The person-centered care plan may require more frequent safety checks and any facility staff member who identifies an unsafe situation, practice or environmental risk factor should immediately notify their supervisor or charge nurse.