

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Sun Mar Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 West Orange Avenue Anaheim, CA 92804	
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, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 1) was provided with the necessary care and services. * The facility failed to ensure Resident 1 received adequate supervision to prevent an elopement (when a resident leaves a safe area without authorization). This failure had the potential to place the resident at risk for accident or injury. Findings: Review of the facility's Elopement and Wandering Residents revised on 5/7/26, showed the facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. In procedure for locating missing resident if the resident is not located in the building or on the grounds, administrator or designee will notify the police department and serve as the designated liaison between the facility and the police department. Review of the facility's Report of Suspected Dependent Adult/Elder Abuse (SOC 341) form dated 6/29/26, showed on 6/29/25 at 1750 hours, a CNA reported Resident 1 was not in the room when dinner trays were being delivered. At 1900 hours, the facility received a call from a community member reporting the resident was wandering in the street near a bus station. Resident 1 returned to the facility at 1920 hours. Review of the CMS Intake Information Report for Intake Number 3065145 dated 6/29/26, showed the incident date as 6/28/26. Review of the facility's document failed to show documentation of facility exit door and security alarm checks prior to Resident 1's elopement on 6/28/26. Closed medical record review of Resident 1 was initiated on 7/8/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/11/26, showed Resident 1 had fluctuating capacity to understand and make decisions related to dementia. On 7/9/26 at 1220 hours, an interview was conducted with RN 1. RN 1 stated she did not know how Resident 1 exited the facility and stated she did not see the resident walk through the front door. RN 1 stated there was an alarm on the back door near the kitchen; however, she did not hear the alarm activate. RN 1 stated the facility staff searched the facility and the nearby area but could not locate the resident. RN 1 stated she did not call the police department. RN 1 added she received a call from a community member reporting Resident 1 was found wandering near a bus station. On 7/9/26 at 1244 hours, an interview was conducted with LVN 2. LVN 2 stated Resident 1 frequently verbalized wanting to go home. LVN 2 stated there should be an alarm in the back door; however, she did not hear any alarm at the time the resident left the facility. On 7/9/26 at 1445 hours, an interview was conducted with the Administrator. The Administrator verified Resident 1 left the facility though the back door near the kitchen, as seen on camera footage. The Administrator stated the camera footage did not show (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	whether the door alarm activated. The Administrator stated the facility did not call the police because the staff attempted to locate the resident first. The Administrator verified a community member contacted the police and informed the facility on 6/28/26 at 1900 hours, the resident was found wandering in the street near a bus station. The Administrator verified there was no documentation of exit door alarm checks prior to Resident 1's elopement. On 7/29/26 at 1645 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		