STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555520	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Leisure Court Nursing Center	1135 Leisure Court Anaheim, CA 92801

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 observation, interview, medical record review, and facility document review, the facility failed to ensure for a safe and secure environment for one of three sampled residents (Resident 1). * Resident 1 left the secured facility without the staff's knowledge, and was located two days later in an emergency department approximately 50 miles away. This failure put the resident at risk for injury while unsupervised in the community, without medications and medical care for an extended period of time.Findings: Review of the facility's faxed notification to CDPH dated 4/25/26 at 1339 hours, showed on 4/24/26 at around 2150 hours, Resident 1 was noted to be missing from the facility. The facility reported Resident 1 was alert with forgetfulness, and able to propel herself in a wheelchair. The resident was last seen by a staff at around 2015 hours. On 4/27/26 at 0854 hours, a telephone interview was conducted with the DON by a HFES. The DON stated Resident 1 had not been located. On 4/27/26 at 1608 hours, the facility reported to the CDPH at 1530 hours, a physician at an acute care hospital's emergency department approximately 50 miles from the facility had informed them Resident 1 checked herself into the emergency department. Review of the facility's Facility assessment dated [DATE], showed the facility is a secured facility. On 4/28/26 at 1040 hours, the facility's front entry door was observed locked from the outside, with a keypad observed by the door. A buzz was heard and the door opened. Upon the door closing, the door was locked. A keypad was observed on the wall next to the door. A receptionist was observed in a room with an open glass partition located across the lobby from the front door entry. On 4/28/26 at 1043 hours, an interview was conducted with the Assistant Administrator and DON. The DON and Assistant Administrator stated they reviewed surveillance camera footage, and the resident was seen leaving the facility on 4/24/26 at 2029 hours, through the secured front door. The DON stated the resident somehow knew the door code, and was able to unlock the door using the keypad and propelled her wheelchair out of the facility. On 4/28/26 at 1055 hours, a facility tour was conducted with the DON. A tall cinderblock wall approximately six feet tall was observed with metal picket fencing curved inwards, on top of the cinderblock wall, extending the wall even higher. The DON stated the facility was a secured facility, the front door was the only door with a keypad lock, and the rest of the exit doors were either unlocked only with a key or they exited to the fenced-in perimeter. On 4/28/26 at 1156 hours, an interview and concurrent observation was conducted with the Assistant Administrator, DON, and Maintenance Assistant to review the surveillance footage. The surveillance footage showed on 4/24/26 at 2029 hours, Resident 1 was entering the video in a wheelchair as she propelled herself towards the front door. Resident 1 was observed punching something into the keypad and pushing the front door to open, and propelling herself through the door. Another camera view was pulled up to show Resident 1 on the sidewalk by the driveway, propelling herself down the sidewalk towards La [NAME] Avenue, until she went past the camera's view. Closed medical record review for Resident 1 was initiated on 4/28/26. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 9/6/25, showed the resident had no capacity to understand and make medical decisions. The resident's diagnoses included schizoaffective disorder, chronic low back pain, (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	depression, and diabetes mellites. Review of Resident 1's Order Summary Report showed the resident had the following physicians' orders dated:- 4/6/26, for Cobenfy 100-20 mg (a medication to treat schizophrenia), administer by mouth twice a day.- 9/5/25, for Seroquel 400 mg (antipsychotic medication used to treat schizophrenia), administer by mouth twice a day.- 9/5/25, for olanzapine 15 mg (antipsychotic medication used to treat schizophrenia), administer by mouth twice a day.- 9/5/25, for Cymbalta delayed release particles 20 mg (a psychotropic medication used to treat depression), administer by mouth twice a day. - 12/3/25, for a lidocaine patch 4% (a topical local anesthetic to treat pain) to be applied to the resident's lower back daily.- 9/5/25, for baclofen 15 mg (a muscle relaxant used for muscle spasms), administer by mouth three times a day. - 11/23/25, for Humulin R insulin (medication used to stabilize high lowering blood sugar levels), administer subcutaneously three times a day per a sliding scale based on current blood sugar levels. - 9/5/25, for metformin HCl 500 mg (a medication used to lower blood sugar levels), administer by mouth twice a day. Review of Resident 1's Elopement Risk assessment dated [DATE], showed the resident scored 18. The form showed a score of 17 or higher was considered high risk for elopement. The form was checked with the box to show the resident was not an elopement risk, and showed the resident was not exit seeking, attended activities of interest, and had not verbalized wanting to leave the facility. The form showed the resident's care plan was reviewed and updated. Review of Resident 1's care plan failed to address the resident's risk for elopement. Review of Resident 1's SBAR Communication Form dated 4/6/26, showed the resident was noted with increased yelling, screaming, responding to internal stimuli (acting on internal sensations, thoughts, or perceptions - such as hallucinations, hunger, or pain - rather than external environmental cues), and crying during cares. On 4/28/26 at 1252 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 1's Elopement Risk assessment dated [DATE], and stated the rationale for why the resident was not an elopement risk was not appropriate, and the resident should have been considered an elopement risk. The DON stated given the resident was an elopement risk, the resident's care plan should have been updated to address it. The DON verified Resident 1's care plan did not address elopement risk. On 4/28/26 at 1313 hours, a telephone interview was conducted with CNA 1. CNA 1 stated he was assigned to Resident 1 on 4/24/26, and last saw Resident 1 at around 2000-2015 hours. CNA 1 stated the resident was in her wheelchair by the employees' lounge and she asked him for a cigarette. CNA 1 stated he explained to Resident 1 he did not have any cigarettes, and it was not time for the scheduled smoking break. CNA 1 stated Resident 1 liked to wheel around inside the facility and would hang out by the front lobby. On 4/28/26 at 1414 hours, an interview was conducted with LVN 1. LVN 1 stated she worked a double-shift on 4/24/26 from 0700 - 2300 hours, and was assigned to Resident 1. LVN 1 stated Resident 1 was able to communicate her needs liked to attend activities, talked on the facility's telephone for resident use, listened to music on her headphones, and went on smoke breaks. Resident 1 would go around inside the facility in her wheelchair, sometimes around by the front lobby area. LVN 1 stated Resident 1 did not bring any personal belongings with her, just a plastic bag she kept on her wheelchair that had papers in it. Resident 1 did not have any medications with her when she left. On 4/28/26 at 1448 hours, a telephone interview was conducted with Resident 1's Responsible Party (Responsible Party 1). Responsible Party 1 stated Resident 1 had been more agitated approximately three to four weeks ago, and Resident 1 asked Responsible Party 1 about going to a different facility she was at in the past, and also told her she had a job interview to go to in San Diego for the Department of Defense, which was not a reality. Responsible Party 1 stated she spoke to Resident 1 on 4/27/26, and when Responsible Party 1 asked Resident 1 how she got so far, the resident told her she just wheeled herself to a bus. Review of Resident 1's ED progress note dated 4/26/26 at 1600 hours, showed the resident presented to the ED with bilateral lower extremity edema, disorganized responses, unusual behavior, and poor hygiene. A psychiatric consultation was requested. Review of Resident 1's Psychiatric ED Consultation progress note dated 4/27/26 at 0639 hours, showed the resident presented acutely psychotic and disorganized thought process. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident responded to internal stimuli with visual hallucinations and visibly tracked something in the air that was not present, the resident admitted to audio hallucinations. Resident 1 was placed on a 5150 hold for being gravely disabled. On 5/6/26 at 1100 hours, an interview was conducted with the DON. The DON was informed of the findings and verified Resident 1 should have been treated as high elopement risk and more closely supervised to ensure the resident's supervision and safety.