

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2025
NAME OF PROVIDER OR SUPPLIER Norwalk Skilled Nursing & Wellness Centre, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 11510 Imperial Highway Norwalk, CA 90650	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425</p> <p>Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), whose cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired, and who was assessed at risk for elopement (the act of leaving a facility unsupervised and without prior authorization), was monitored to prevent him eloping from the facility.</p> <p>This deficient practice resulted in Resident 1 eloping from the facility, on 4/1/2025 at approximately 7 p.m. Resident 1 was found by a good Samaritan on 4/2/2025, approximately 14 miles from the facility, he was transferred to a General Acute Care hospital (GACH) for evaluation before being readmitted to the facility on [DATE]. This deficient practice had the potential for Resident 1 to continue to be missing, injury and death.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).</p> <p>During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 3/11/2025, the MDS indicated Resident 1's cognition was severely impaired, and he required supervision or touch assistance (when a helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity, assistance may be provided throughout the activity or intermittently) to walk.</p> <p>During a review of Resident 1's Elopement Evaluation dated 3/11/2025, the Elopement Evaluation indicated a score of two which indicated a risk of elopement.</p> <p>During a review of Resident 1's Care Plan dated 6/6/2024, the Care Plan indicated Resident 1 was at risk for wandering/elopement. Under this Care Plan a goal for Resident 1 was for him not to leave the facility unattended. The Care Plan's interventions included identifying Resident 1's triggers for wandering/eloping. The Care Plan's documentation did not indicate what triggers to look for.</p> <p>During a review of Resident 1's Change in Condition (COC) dated 4/1/2025, the COC indicated Resident 1 was missing at 7 p.m.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/3/2025 at 9:50 a.m., the facility's receptionist desk was observed in a hall to the right of the facility's front door, which was approximately 20 feet from the front door, and when standing directly in front of the receptionist desk, there was no direct view of the front door or the hallway leading to the front door.</p> <p>During an interview on 4/3/2025 at 12:31 p.m., the Receptionist 1 (RC 1) stated she did not have a clear visual line that allowed her to monitor the front door and in order to monitor residents who got near the front door she had to lean to the left to see them when she was sitting at the receptionist desk.</p> <p>During an interview on 4/3/2025 at 2:53 p.m., RC 2 stated one of his job responsibilities was to ensure residents did not go out of the front door and the reception desk should not be left unattended. RC 2 stated on 4/1/2025, he was outside on the main patio from 6 p.m., until 6:15 p.m., with another resident, and did not see Resident 1 outside. RC 2 stated, at approximately 7 p.m., Registered Nurse 1 (RN 1) notified him that Resident 1 was missing.</p> <p>During an interview on 4/3/2025 at 3:58 p.m., RN 1 stated the last time she saw Resident 1 was in the dining room at 6:15 p.m., watching television. RN 1 stated she left Resident 1 alone in the dining room because he was finished eating dinner and he was just watching television. RN 1 stated RC 2 was at the receptionist desk, and she (RN 1) went to the nurses' station, which was down the hall from the dining room, but stated she could not see the dining room from the nursing station. RN 1 stated at approximately 7 p.m., during her rounds, she checked Resident 1's room and bathroom, and he was not there. RN 1 stated when the dining room was checked, Resident 1's wheelchair was there but he was not.</p> <p>During an interview on 4/4/2025 at 12:32 p.m., the Administrator (ADM) stated Resident 1 mostly like eloped through the facility's front door.</p> <p>During an interview on 4/4/2025 at 1:10 p.m., the Director of Nursing (DON) stated the receptionist when sitting at the front desk, does not have direct view of the front door, and she would have to lean to the left to view the hallway that leads to the front door, and the receptionist could potentially miss a resident who attempted to or walked out of the front door. The DON stated residents should not be left alone in the dining room because anything could happen to the resident, like a fall. The DON stated before 8 p.m., the alarm on the front door is not turned so it was possible for a resident to leave out of the front door undetected before 8 p.m.</p> <p>During a review of the facility's policy and procedure (P/P) dated 1/31/2023, titled, Wandering and Elopement, the P/P indicated the resident's risk for elopement and preventative interventions will be documented in the resident's medical record and the IDT will develop a plan of care considering the individual risk factors of the resident.</p>		