STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555867	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest Hill Manor Health Center	551 Gibson Avenue Pacific Grove, CA 93950

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 - 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
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(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 - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received adequate monitoring to prevent an elopement (leaving the facility without authorization) for one of two sampled residents (Resident 1). Resident 1's elopement assessment indicated she was at risk for elopement, and a care plan was not developed upon admission. On 6/27/25, Resident 1 eloped, was found the next day on 6/28/25 in the neighborhood, transferred to a hospital, was noted to have hypothermia (significant and potentially dangerous drop in body temperature with most common cause from exposure to cold weather) and sustained injuries of forehead laceration (cut) requiring suturing.This failure resulted in Resident 1 having multiple bodily scratches/abrasions, hypothermia, altered mental status, rhabdomyolysis (breakdown of muscle tissue that releases a damaging protein into the blood), forehead laceration and urinary tract infection. Findings:Review of Resident 1's Nurse's Note, dated 6/27/25 at 11:23 p.m., indicated around 4 p.m. the resident was walking in the hallway back and forth and went into another resident's room. It indicated about 4:15 p.m., Resident 1 was not in her room, all staff were informed, and a search began, and at 4:39 p.m. the police were notified.Review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 6/10/25, indicated the resident's Brief Interview for Mental Status (BIMS) score was 3 out of 15, indicating she had memory problems and severe impairment in daily decision-making skills.Review of Resident 1's admission Elopement - Wandering (moving from place to place without a clear goal or direction) assessment dated [DATE], scored seven, indicating the resident was at moderate risk for elopement. Under Recommendations for Safety, it indicated routine rounding, bed to low position, and resident had a sitter (non-medical staff who provides continuous, one-on-one supervision for residents at risk of injury, such as falls) in the evening. There was no documented evidence a care plan was developed addressing Resident 1's risk for elopement. During an interview on 9/3/25 at 1:24 p.m., the director of nurses (DON) stated Resident 1 walked independently without assistive devices (i.e. cane, walker), had a sitter during the beginning of her admission because she was at high risk for fall. The DON stated on the day of elopement on 6/27/25, the family member did not visit, and Resident 1 was seen on the street (Fountain Street) by a visitor near the back exit walking uphill. The DON who reviewed the record stated Resident 1 was assessed at risk for wandering/elopement and a care plan should have been developed.During a tour and interview with RN A on 9/3/25 at 2:38 p.m. It was observed there are three exits including the main entrance leading to public street and one exit to a back pubic street. RN A during the tour of the facility stated none of the exit doors leading to public streets were alarmed.Review of Resident 1's Fall Risk Assessment form, dated 6/6/25, indicated the resident was at high risk for falls. A fall monitoring log to document hourly from midnight to 11 p.m. was initiated on 6/7/25 at midnight f or Resident 1. The monitoring log was not consistently completed; entries were missing on 6/12/25 from midnight to 2 p.m., 6/13/25 from 4 p.m. to 11 p.m.6/17/25 from 8 a.m. to 11 p. m., 6/18/25 from 8 a.m. to 2 p.m.,6/18/25 from 4 p.m. to 11 p.m., 6/19/25 and 6/20/25 from 4 p.m. to 11 p.m., 6/21/25 from 7 a.m. to 11 p.m., 6/23/25 from midnight to 7 a.m., 6/24/25 from 1 p.m. to 11 p.m., 6/25/25 from 4 p.m. to 11 p.m., and 6/26/25 from 4 p.m. to 11 p.m. with no explanation for no documentation. Also, the fall monitoring log dated 6/27/25 during the times Resident 1 was missing from 5 p.m. to 11 p.m., indicated Resident 1 was monitored for falls in the facility.During an interview on 9/3/26 at 2:40 p.m., the DON who reviewed the monitoring log acknowledged the monitoring entries were not complete.During an interview on 9/18/25 at 3:10 p.m., the certified nurse assistant (CNA) confirmed he initialed Resident 1's Monitoring Log on 6/27/25 from 4 p.m. to 11 p.m. The CNA stated Resident 1 was missing and he made a mistake in documentation in the fall monitoring log.During an interview on 9/25/25 at 11:07 a.m. the DON stated the facility did not have a wander guard (system with bracelets and sensors at doorway and a central platform that sends alerts to staff when a person approached a restricted area) and no alarm system.During an interview on 10/1/25 at 3:15 p.m., the social services director (SSD) stated Resident 1 had a sitter paid by the family on 6/6/25 from 7 a.m. to 7 p.m. The sitter service was discontinued on 6/10/25 after she discussed with a family member the resident did not need a sitter.Review of the Pacific Grove Police Department (PGPD) report, dated 6/27/25 at 9:29 p.m., indicated the California Highway Patrol activated a Silver Alert (pubic notification issued by law enforcement for a missing adult who is 65 or older and is considered at risk of harm due to their condition or the circumstance of their disappearance) for Resident 1 within a 3-mile radius of the area, a missing person flyer was posted on the PGPD's social media accounts for citizens to be