

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555894	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026
NAME OF PROVIDER OR SUPPLIER Foothill Heights Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 North Fair Oaks Ave Pasadena, CA 91103	
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** Based on interview and record review the facility failed to ensure one (1) of two sampled residents (Resident 1) with history of attempted elopement (occurs when a resident leaves a facility without authorization or supervision) was provided safety protocols, supervision and ensure monitoring to prevent elopement when the front door was left unsupervised on 3/14/2026 around 9 pm. This failure resulted in Resident 1 having a successful elopement and had the potential to lead to endangerment, accident and injury while outside the facility's premises without supervision from staff. Resident 1 was returned to the facility on 3/15/2026 at 1:15 PM. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included but not limited to unsteadiness of feet, other schizoaffective disorders (a mental health problem where a person experiences loss of contact with reality as well as mood symptoms), and other specified anxiety disorders (fear characterized by behavioral disturbances). During a review of Resident 1's Minimum Data Set (MDS- a Resident assessment tool), dated 12/30/2025, the MDS indicated Resident 1 was assessed having moderately impaired (decisions poor; cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 was independent with oral/personal hygiene, upper/lower body dressing, and eating. The MDS indicated Resident 1 required setup or clean-up assistance with sit to stand, toilet transfer, and walking 150 feet (ft.- unit of measurement). During a review of Resident 1's Care Plan, initiated on 1/2/2026, the care plan indicated Resident 1 was at risk for wandering/elopement as evidenced by attempts to leave the facility unattended and impaired safety awareness. The care plan indicated Resident 1 drifted away from the smoking group and redirected back to the facility on 1/2/2026. The Care Plan interventions included door monitoring every shift and maintaining a safe and hazard-free environment. During a review of Resident 1's Change of Condition form, dated 1/2/2026, at 12:49 PM, the Change of Condition form indicated on 1/2/2026, at 12:49 PM, Resident 1 attempted to elope while smoking outside. During a review of Resident 1's Elopement Risk Evaluation form, dated 1/2/2026, the Elopement Risk Evaluation form indicated a total elopement risk score of 9 (a total score of 10 or higher indicated at risk for elopement). However, the Elopement Risk Evaluation form also indicated Resident 1 has verbally expressed the desire to go home, packed belongings to go home, or stayed near exit door. The Elopement Risk Evaluation form further indicated, under Summary of Review, that Resident 1 was at risk for elopement/wandering. During a review of Resident 1's Elopement Incident form, dated 3/14/2026, the Elopement Incident form indicated Resident 1 was last observed at approximately 8:40 PM sitting in her wheelchair near the nursing station. At approximately 9 PM Charge Nurse (CN) went to Resident 1's room to administer Resident 1's scheduled nighttime medications. Resident 1 was not present in the room. Immediate attempts were made to locate Resident 1 within the unit and surrounding areas; Resident was not found. A bus was noted in front of the facility, and staff searched for the bus as part of the elopement search; the Resident was not located. Resident 1's Elopement Incident form indicated the elopement occurred by the front door. (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 the same review of Resident 1's Elopement Incident form, dated 3/14/2026, the Elopement Incident form indicated Resident 1 stated she left the facility through the front door and Resident 1 reported she was going to Oregon. During an interview on 3/26/2026, at 11:58 AM, with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the front door was always supervised by facility staff because it did not have an alarm. CNA 1 stated the front door was also locked at night for safety reasons. CNA 1 stated she supervised the front door on 3/14/2026 from 8 PM to 8:30 PM. CNA 1 stated Resident 1 was not by the front door or the Nurse's Station while she was supervised the front door. CNA 1 stated at approximately 9 PM, Licensed Vocational Nurse 1 (LVN 1) informed her that Resident 1 was missing in the facility. During an interview on 3/26/2026, at 12:20 PM with CNA 2, CNA 2 stated facility staff supervised the front door to make sure the residents do not leave the facility. CNA 2 stated she last saw Resident 1 in the hallway on 3/14/2026 at approximately 8:40 PM, when she got her lunch. CNA 2 stated at 9 PM, LVN 1 stated Resident 1 was missing and called a Code [NAME] (an emergency code for elopement). During an interview on 3/26/2026, at 2:19 PM with LVN 1, LVN 1 stated there facility staff always supervised the front door to monitor residents and make sure the residents are safe. LVN 1 stated on 3/14/2026, at around 8:40 PM, Resident 1 was sitting in her wheelchair by the Nurse's Station while CNA 3 supervised the front door. LVN 1 stated she left the Nurse's Station soon after 8:40 PM to administer medications and arrived at Resident 1's room at 9PM to administer her medications. LVN 1 stated Resident 1 was not in her room at 9 PM so she went back to the Nurse's Station because that was the last place where she last saw Resident 1. LVN 1 stated when she arrived at the Nurse's Station, Resident 1's wheelchair was there but could not find Resident 1. LVN 1 stated the front door was not supervised by CNA 3 when she went to the Nurse's Station to look for Resident 1. LVN 1 stated she was not sure how Resident 1 was able to leave the facility if the front door was locked because Resident 1 was sometimes unsteady when she stood or walked. LVN 1 stated a Code [NAME] was called because they did not find Resident 1 in the facility. During an interview on 3/26/2026, at 2:31 PM, with Social Services Director (SSD), SSD stated the front door was supervised and monitored by facility staff make sure the residents are safe and do not leave the facility. SSD stated the front door should not be left unattended. SSD stated the residents' safety was the facility's priority. During a concurrent interview on 3/26/2026, at 2:44 PM, with the Director of Nursing (DON), the DON stated the front door was supervised by staff for the safety of the residents because it opens directly to a busy street. The DON stated Resident 1 would not have been able to leave the facility if the front door was supervised on 3/14/2026 at around 9 PM. During a review of the undated facility's policy and procedure (P&P), titled, Wandering and Elopements, the P&P indicated that the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. During a review of the facility's P&P, titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated the following:The facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.Implementing interventions to reduce accident risks and hazards shall include ensuring the interventions are implemented.Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment.</p>		