

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056042	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Bay Vista Healthcare & Wellness Centre, LP		STREET ADDRESS, CITY, STATE, ZIP CODE 5901 Downey Ave Long Beach, CA 90805	
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** 50144 Based on interview and record review, the facility failed to ensure a resident, who lacked the capacity to make decisions, was supervised, and monitored to prevent one of three sampled residents (Resident 1) from eloping (leaving a secured institution without notice or permission) from the facility. Resident 1 was last seen in the facility on 12/12/2024 at approximately 10:30 p.m in his room. Resident 1 was noted missing on 12/12/2024 at approximately 11:30 p.m. As of 12/20/2024, Resident 1 has not been located. This deficient practice resulted in Resident 1 ' s eloping from the facility on 12/12/2024 and his whereabouts being unknown. This deficient practice had the potential for Resident 1 to be exposed to excessive drops in temperature, motor vehicle accidents, hunger, dehydration, and death. Findings During a review of Resident 1 ' s General Acute Care Hospital (GACH) records dated 8/19/2024, the GACH records indicated Resident 1 was admitted to the GACH on 8/9/2024 for aggressive behavior and was put on a hold ([psychiatric (relating to mental illness or it's treatment) hold] a legal process that allows a person to be involuntarily detained in a psychiatric hospital for up to 72 hours if they are a danger to themselves or others or gravel disabled). The records indicated on 8/18/2024, Resident 1 had irrational (not reasonable) thought process is very demented (behaving wildly), talking to himself, easily distracted and very anxious. The GACH records inciated .Resident 1 had poor attention and poor concentration, poor insight and poor impulse control. During a review of Resident 1 ' s Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with the diagnoses including Type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing), bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs) paranoid schizophrenia (a mental illness that can affect thoughts, mood, and behavior that includes delusions and hallucinations), and suicidal ideation (thinking about or formulating plans for suicide). During a review of Resident 1 ' s History and Physical (H&P) dated 8/21/2024, the H&P indicated Resident 1 had fluctuating (rises and falls unpredictably) capacity to understand and make decisions. (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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(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	During a review of Resident 1 ' s Minimum Data Set ([MDS] a resident assessment tool) dated 11/27/2024, the MDS indicated Resident 1 had moderate cognitive (ability to think and reason) impairment, and Resident 1 required supervision or touching assistance (Helper provides verbal cues or touching/steadying and or contact guard assistance) to complete his activities of daily living ([ADLs] routine tasks/activities such as eating, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1 ' s Psychiatry Follow up Note dated 11/4/2024, the Psychiatry Follow up note indicated Resident 1 had disorganized through processes and had poor judgement and insight. During a telephone interview on 12/19/2024 at 12:54 p.m., Certified Nurse Assistant (CNA) 1 stated on 12/12/2024 around 10:30 p.m., CNA 1 observed Resident 1 in his room. CNA 1 stated Resident 1 was able to walk to the bathroom independently but used a wheelchair to go to the smoking patio. During a telephone interview on 12/19/2024 at 4:51 p.m., Licensed Vocational Nurse (LVN) 1 stated on 12/12/2024 around 11:10 p.m. LVN 1 completed their rounds and noticed Resident 1 was not in his room. LVN 1 stated they asked other CNA ' s to look for Resident 1. LVN 1 stated the CNA ' s informed LVN 1 that Resident 1 was unable to be located inside the facility on 12/12/2024 at approximately 11:30 p.m. During a concurrent observation and interview on 12/20/2024 at 11:45 a.m. with the Maintenance Supervisor (MS), the kitchen door with access to the main street was observed. The MS stated the kitchen door was not secured with an alarm system. The door is accessed only by kitchen staff and is locked when kitchen staff are not present. During an interview on 12/20/2024 at 12:40 p.m., the Administrator (ADM) stated Resident 1 unknown whereabouts placed Resident 1 at risk for physical harm related to lack of supervision and lack of medications to manage Resident 1 ' s psychiatric behaviors. During a review of the facility ' s policy and procedure (P/P) titled Resident Safety dated 4/15/2021, the P/P indicated the facility will provide a safe and hazard free environment.		