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

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555726	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER: Mar Vista Country Villa Healthcare & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE: 3966 Marcasel Ave, Los Angeles, CA 90066	

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. 45528 Based on observation, interview, and record review, for one of three sampled residents (Resident 1), facility failed to: 1. Adequately monitor and supervise Resident 1 to prevent elopement (to leave a health care or educational facility without permission or authorization) according to the facility ' s policy and procedures (P&P), titled, Wandering and Elopement, dated 2/10/2023 2. Ensure alarm system was in place on two of seven exit doors to alert staff if a resident was eloping and or exiting the facility. 3. Ensure the front desk was monitored daily from 7:30 P.M., to 8 A.M., These deficient practices resulted in Resident 1 eloping from the facility on 11/22/2024 at 3:45 A.M., placing the resident at increased risk for extreme weather, medical emergencies, accidents, injuries, hospitalization , and/or death. Findings: During a review of Resident 1's Admission Record indicated the facility admitted Resident 1 on 7/5/2024 with diagnoses including metabolic encephalopathy (imbalance in the body ' s chemical causing the brain not to work properly), unspecified altered mental status (not thinking clearly or having trouble focusing), and diabetes (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 10/12/2024, indicated Resident 1 was cognitively intact (when a person can remember, learning new things, concentrate, or making decisions that affect their everyday life). The MDS indicated Resident 1 required supervision to set up/clean up assistance from staff for Activities of daily living. During a review of Resident 1's Multidisciplinary care conference (a group of healthcare professions from different disciplines working together to take care of the patient) notes date 10/17/2024, the multidisciplinary care conference note indicated, a. Summary of Recommendations . Resident (Resident 1) lived with his [family members] who raised a concern of resident wandering around and might stress his (family member). (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	During a review of Resident 1's History and Physical (H&P -a comprehensive assessment of the patient ' s health) dated 11/14/2024, the H&P indicated, the patient is having memory loss. The patient has flatulating capacity to make medical decisions. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 11/22/2024, the SBAR indicated Licensed Vocational Nurse 1 (LVN 1) documented that on 11/22/2024 at 3:45 A.M., Certified Nursing Assistant 1 (CNA 1) reported that Resident 1 was no longer in the bed and could not be found in the room. the SBAR indicated facility staff was searched, each room, the patio, the basement, the kitchen but locate the resident. The SBAR indicated LVN 1, and CNA 1 went out to search the community and were not able to find the resident. During a review of Resident 1's Nursing Progress Notes dated 11/22/2023 at 2:49 P.M., the nursing progress notes indicated, Director of Staff Development (DSD) documented that on 11/22/2024, at 10:53 A.M., LVN (unknown) called the facility to notify staff that she had found Resident 1 at the bus stop. During a concurrent observation and interview on 11/23/2024, at 10:20 A.M., with Registered Nurse Supervisor (RNS), tour of the facility, the main entrance door, the exit door in the lobby area and the double doors between the resident ' s room and the lobby area did not alarm on exit. RNS stated the doors do not have an alarm system that activates should a resident or staff member exit through them. RNS states there is only a wander guard keypad that alarms only when a resident with a wander guard goes close to it. During an interview on 11/23/2024, at 1:16 P.M., with CNA 1, CNA 1 stated, he was making resident rounds on 11/22/2024 at around 3:45 A.M. and noticed Resident 1 was not in the room. CNA 1 stated he looked for Resident 1 in the bathroom, and the patio and notified LVN 1 when he could not locate the resident. CNA 1 stated that himself, LVN 1 and all staff who were working on that night looked throughout the entire facility and around the neighborhood for hours and they could not locate Resident 1. CNA 1 stated Resident 1 sometimes goes to the wrong room, and we (staff) have to remind him where his room is. CNA 1 stated Resident 1 did not have a wander guard. CNA 1 stated he makes rounds on the residents every hour however, there is no documentation to show proof that he made rounds. CNA 1 further stated we should document so that what just happened to Resident 1 does not happen. He [Resident 1] left the facility without us knowing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/23/2024, at 1:43 P.M., with LVN 1, LVN 1 stated on the day of the incident, 11/22/2024, she came back from break at around 3:30 A.M., when CNA 1 told her that CNA 1 was unable to find Resident 1 in his room. LVN 1 stated facility staff on duty that night searched the entire facility, the area around the facility by foot and by car and Resident 1 was nowhere to be found. LVN 1 stated she then notified the Director of staff development (DSD) who stated she was on her way to the facility and that DSD would also notify the Director of Nursing (DON). LVN 1 stated she and the DSD called the police, the police officers came and searched the facility with the staff and Resident 1 was nowhere to be found. LVN 1 stated she was in a car going home on 11/22/2024 at around 10:40 A.M., when she saw Resident 1 seating at a bus stop. LVN 1 stated she asked Resident 1 what happened, and the resident told LVN 1, I just wanted to get out. LVN 1 stated Resident 1 is forgetful and needs repeated instructions. LVN 1 stated Resident 1 had a wander guard (a device that alerts staff if someone at risk has left the department and allows staff to respond quickly and help) before but no longer had one including the day the resident eloped. LVN 1 stated she makes rounds on residents at least every 30 minutes, however, LVN 1 was not able to provide any documented for resident rounding. LVN 1 stated, I think there should be documentation done for rounding to show that we are doing as much as we are supposed to, to show proof that we did round and what time we rounded. During a concurrent observation and interview on 11/23/2024, at 3 P.M., with the Maintenance Director (MD), MD stated the facility does not have any alarms on all exit doors. MD stated, as you can see, he (pointing at a gentleman placing equipment on the main entrance door/by area to the facility) he is putting an alarm on that door (main entrance) and then he will also be putting an alarm on that door (point to the exit door between the Business of and the MDS/CM office. MD stated, facility doors did not have any alarm system on them, and that the vendor was here to install alarms on all the exit doors in the facility so that the residents do not leave the facility without the staff knowing like what just happened. During an interview on 11/26/2024, at 1:25 P.M., with the Director of Nursing (DON), the DON stated, facility does not have anyone at the front desk from 7:30 P.M., to 8 A.M., and that no one can come into the facility because the doors are looked however, anyone including residents can leave the facility without being detected. The DON stated, wandering is defined as confused, trying to look for something and going from room to room. The DON stated the potential adverse outcome of a resident leaving the facility unsupervised include the resident being run over by traffic, get cold, hungry and may be at risk for hypoglycemia and hypertension. The DON stated, when asked where he went and why, Resident 1 wanted to get food, take a walk, and just went for a walk; I didn ' t know that I had to tell someone when I want to walk. The DON stated wandering is confused, trying to look for something, going from room to room, in the hallways. It can harm other patient, female patient can be fearful -invasion of privacy, invasion of personal space, possible, physical altercation -altercation -harm himself, possible they can wonder off to the exit door. The DON stated facility staff need to round on residents every two hours to ensure that all residents are accounted for however, facility does not have any documentation to show that the staff rounded on the residents. The DON stated facility should have documentation to show that the staff rounded on the residents. The DON stated Resident 1 did not have a wander guard at the time of the incident we have it now. It is important to have one (wander guard), if we had it (wander guard), we would have prevented him from going out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P), titled, Resident Safety, revised 4/15/2021, indicated, the purpose of the policy is to provide a safe and hazard free environment . to observe the safety and wellbeing of the residents, 1. During the comprehensive assessment period of the interdisciplinary team IDT) members will assess the Resident's safety risk (e.g . elopement . etc.) as well as any other resident safety risks. a. Resident check will be made at least two hours around the clock the clock by nursing service personnel. During a review of the facility's P&P, titled, Wandering and Elopement, dated 2/10/2023, indicated Elopement - A behavior that may lead to the resident leaving the facility unsupervised and/or without permission.