STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555726	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mar Vista Country Villa Healthcare & Wellness	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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
	555726	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mar Vista Country Villa Healthcare & Wellness	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews for two of three sampled residents, Resident's 1 and 2. The facility failed to prevent a third incident of resident-on-resident altercation.This deficient practice caused Resident 1 to go to Resident 2's new room and provoke a fight which led to Resident 1 hitting Resident 2 on the nose and Resident 2 hitting Resident 1 on the back of the head.Cross Reference: F609.Findings:A review of Resident 1's admission Record indicated the facility originally admitted this [AGE] year old male on 12/2/2024 and most recently on 7/3/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Anxiety disorder (feelings of persistent fear and worry), hypothyroidism (thyroid gland does not produce enough thyroid hormone), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), other abnormalities of gait (walking) and mobility, hyperlipidemia (HLD-high fat in the blood), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), coronary artery (- a slow progressive separation of the layers of the heart vessels) dissection and atrial fibrillation (heart dysrhythmia).A review of Resident 1's Minimum Data Set (MDS- a resident assessment) dated 7/10/2025 indicated Resident 1's cognition (mental ability to make decisions for daily living) was intact. The MDS indicated Resident 1 required set up assistance (Helper sets up or cleans up; resident completes activity. Helper only assists before or after activity) with toileting and showering. Resident was independent (Resident completes activity by themselves with no assistance from helper), with transfers (moving between surfaces) from bed to chair.A review of Resident 1's care plan titled, The resident exhibits behaviors including fabricating and confabulating stories, provoking other residents into arguments and fights, hitting the medication cart, making false accusations and demonstrating inappropriate behaviors towards staff initiated 1/13/2025, revised 6/25/2025. One goal was the resident will effectively express concerns and needs without resorting to verbal or physical aggression. Interventions included monitoring and document instances of inappropriate behaviors, including triggers, frequency and responses. Maintain a behavior log to identify patterns and inform care strategies.A review of Resident 1's care plan titled, Resident exhibits verbal aggression including use of profanity and racial remarks, during interpersonal conflicts with roommate initiated 8/12/2025. Includes goal that physical altercations will be prevented through early interventions and staff monitoring. Interventions include maintaining separate living arrangements, when possible, to reduce direct triggers and prevent escalation. Implement and maintain safety precautions during high-risk interactions (i.e. increased staff presence)A review of Resident 1's care plan initiated 8/11/2025 titled, Resident exhibits verbal aggression characterized by the use of inappropriate offensive, and racially charged language towards staff, causing distress and disruption in care environment such as the N word and black B word and similar expressions. The care plan does not include any goals. The intervention listed is to ensure staff have clear protocol for managing verbal aggression to maintain safety and a respectful care environment.A review of Resident 2's admission Record indicated the facility admitted this [AGE] year-old male on 7/16/2025 with diagnoses including Osteomyelitis (inflammation of bone or bone marrow, usually due to infection), HLD, difficulty walking, Essential hypertension (HTN-high blood pressure) and DM.A review of Resident 2's MDS dated [DATE] indicated Resident 2's cognition (mental ability to make decisions for daily living) was intact. Resident 2 required moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting, showering and transfers (moving between surfaces) from bed to chair.During a review of Resident 1's SBAR communication form (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 7/31/2025 indicated while unnamed licensed Vocational Nurse (LVN) was in room administering intravenous (IV) medication to Resident 2, Resident 1's table was moved from the walkway. After which Resident 1 became angry and verbally aggressive toward the unnamed LVN. Resident 2 then asked Resident 1 to be nice, and Resident 1 began cursing at both the unnamed LVN and Resident 2. Resident 1 then walked up to Resident 2 and lifted the cane towards Resident 2 as if Resident 1 was going to hit Resident 2 with the cane. Room changes offered, however both residents refused. The medical doctor (MD) 1 was informed however the unnamed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555726	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mar Vista Country Villa Healthcare & Wellness	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555726	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mar Vista Country Villa Healthcare & Wellness	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review for two of three sampled residents, (Resident 1 and 2) the facility failed to report an incident of verbal abuse to the California Department of Public Health (CDPH) and failed to report an incident of physical abuse timely.This deficient practice placed Residents 1 and 2 at risk for further abuse. Cross Reference: F600.Findings:A review of Resident 1's admission Record indicated the facility originally admitted this [AGE] year old male on 12/2/2024 and most recently on 7/3/2025 with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), Type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Anxiety disorder (feelings of persistent fear and worry), hypothyroidism (thyroid gland does not produce enough thyroid hormone), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), other abnormalities of gait (walking) and mobility, hyperlipidemia (HLD-high fat in the blood), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), coronary artery (- a slow progressive separation of the layers of the heart vessels) dissection and atrial fibrillation (heart dysrhythmia).A review of Resident 1's Minimum Data Set (MDS- a resident assessment) dated 7/10/2025 indicated Resident 1's cognition (mental ability to make decisions for daily living) was intact. The MDS indicated Resident 1 required set up assistance (Helper sets up or cleans up; resident completes activity. Helper only assists before or after activity) with toileting and showering. Resident was independent (Resident completes activity by themselves with no assistance from helper), with transfers (moving between surfaces) from bed to chair.A review of Resident 2's admission Record indicated the facility admitted this [AGE] year-old male on 7/16/2025 with diagnoses including Osteomyelitis (inflammation of bone or bone marrow, usually due to infection), HLD, difficulty walking, Essential hypertension (HTN-high blood pressure) and DM. A review of Resident 2's MDS dated [DATE] indicated Resident 2's cognition (mental ability to make decisions for daily living) was intact. Resident 2 required moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting, showering and transfers (moving between surfaces) from bed to chair.During a review of Resident 1's SBAR communication form (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 7/31/2025 indicated while unnamed licensed Vocational Nurse (LVN) was in room administering intravenous (IV) medication to Resident 2, Resident 1's table was moved from the walkway. After which Resident 1 became angry and verbally aggressive toward the unnamed LVN. Resident 2 then asked Resident 1 to be nice, and Resident 1 began cursing at both the unnamed LVN and Resident 2. Resident 1 then walked up to Resident 2 and lifted the cane towards Resident 2 as if Resident 1 was going to hit Resident 2 with the cane. Room changes offered, however both residents refused. The medical doctor (MD) 1 was informed however the unnamed LVN was awaiting a response.During a review of Resident 1's SBAR dated 8/10/2025 indicated at 9:05 a.m. Resident 1 was yelling, cursing and accusing Resident 2 of stealing a shirt. Resident 2 then became upset and yelled back at Resident 1, both exchanging verbal, racial remarks. Safety precaution measures were implemented, and residents were relocated to prevent further escalation. MD 1 was informed and recommended to monitor and redirect as needed.During an interview on 8/27/2025 at 1:35 p.m. with the medical doctor (MD). The MD stated Resident 1 should have been discharged a long time ago. Resident 1 had no skilled need to be here. Resident 1 left the facility often driving a vehicle. Resident 1 was very aggressive and attacked multiple residents.During an interview on 8/27/2025 at 2:13 p.m. with LVN. The LVN stated, Resident 2 never stole Resident 1's shirt. Resident 1 had all belongings locked in a closet and Resident 1 was the only one with a key to that closet.A record review of Resident 2's Nursing progress note dated 8/10/2025 timed 4:00 p.m. indicated the unnamed LVN encouraged Resident 2 to switch rooms for safety, Resident 2 initially refused then agreed to move to another room.During an interview on 8/27/2025 at 2:00 p.m. with the Director of Medical Records (DMR). The DMR stated there was no SBAR dated 8/11/2025 found in either Resident 1 nor Resident 2's chart.During a concurrent interview and record review on 8/27/2025 at 3:55pm with the Licensed Vocational Nurse (LVN), Resident 1's Nursing progress dated 8/11/2025 timed at 2:16 p.m. was reviewed. The progress note was struck out indicating a reason: wrong