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	11/06/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (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 0725 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 the facility failed to provide sufficient staffing to maintain supervision for one of four sampled residents (Resident 1) who was identified as a wanderer and a high risk of fall.This deficient practice caused Resident 1 to wander outside onto the patio and sustain an unwitnessed fall leaving a laceration (cut) over Resident 1's left eye that required transport to the general acute care hospital (GACH) where Resident received sutures (a row of stitches holding the edges of a wound together).A review of Resident 1's admission record indicated the facility originally admitted this [AGE] year old female on 4/18/2022 and most recently on 4/28/2025 including the following diagnoses, atrial fibrillation (irregular heart beat), supraventricular tachycardia (extremely fast heart beat), hypertensive heart disease (a group of heart problems caused by long term high blood pressure), hyperlipidemia (high fat in the blood), iron deficiency anemia (a condition where the body does not have enough healthy red blood cells), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of right and left shoulder, major depressive disorder (persistent low mood), cardiomegaly (enlarged heart), gastro-esophageal disorder (heartburn), diaphragmatic hernia with obstruction, dysphagia (difficulty swallowing) and dorsalgia (back pain). A review of Resident 1's Minimum Data Set (MDS- a resident assessment) dated 10/16/2025 indicated Resident 1's cognition (mental ability to make decisions for daily living) was not intact. Resident 1 required set up or clean up assistance (helper sets up or cleans up; resident completes activity, helper assists only prior to or following the activity) with toileting and walking. Resident 1 required supervision or touch assistance (helper provides verbal cues and or touching/steadying and or contact guard assistance as resident completes activity) with bathing.A review of Resident 1's physician order dated 9/7/2025 indicated visual hourly checks, check the resident every hour to ensure the resident is safe and free from falls, document the visual check was completed on the medication administration record (MAR- legal document where licensed staff document administration of medications).A review of Resident 1's elopement (leaving facility without notifying staff) risk assessment dated [DATE] indicated resident was at risk of elopement.A review of Resident 1's physician order dated 10/1/2025 indicated apply wander bracelet (wearable device that is part of a larger alarm system to prevent wandering among individuals with cognitive impairment) to right ankle as ordered to alert staff secondary to high risk of elopement. A review of Resident 1's MAR dated 10/21/2025 indicated a y for yes next to hourly visual checks.A review of Resident 1's SBAR communication form dated 10/22/25 indicated Upon returning to check on Resident 1, The CNA noted Resident 1 was no longer in bed. The resident was subsequently found outside on the patio, lying on the ground, with skin flap noted above the eyebrow. Resident 1 complained of head pain rated 7/10. Resident 1's blood pressure was 209mmHg/109mmHg (Normal range 120mmHg-140mmHg/60mmHg-90mmHg) and heart rate was 80 (bpm-beats per minute) (normal range between 60bpm-100bpm).A review of Resident 1's nursing progress note dated 10/22/2025 indicated on 10/21/2025 at 11:00pm Resident 1 was observed sitting in a chair outside of the room. On 10/22/2025 at 12:00am Resident 1 was again helped go back to bed. At 1:00am Resident 1 was noted wandering in the hallway and assisted back to bed. At 3:00 am Resident was observed wandering again and refused to go back to bed so Resident 1 was placed in a chair. At 3:40 am Resident 1 was noted wandering in the hallway and assisted back to bed.Resident 1's GACH records dated 10/22/2025 indicated cat scan (CT scan-imaging scan) of brain results indicated no evidence of acute trauma. An x ray to the left knee indicated no evidence of acute trauma. Diagnosis forehead laceration, abrasion to left knee and closed head injury. Resident 1 was also given hydralazine (medication to treat high blood pressure), lisinopril (medication to treat high blood pressure) and metoprolol (medication to treat high blood pressure) for elevated blood pressure. Lastly, Resident 1 received sutures to eyebrow to be removed in 5-7 days.A review of a statement from CNA 2 dated 10/24/2025 indicated at approximately 3:30am Resident 1 was observed pacing the hallway and was assisted back to the room and placed in bed. After providing care to another resident staff returned to check on Resident 1 and Resident 1 was not in bed. Resident 1 was found outside on the patio. The CN was immediately notified and responded to assist. 911 was called and Resident 1 was transferred to the GACH for further evaluation.A review of a statement from the CN dated 10/24/2025 indicated at approximately 4:00 am CNA 2 notified CN that Resident 1 was found outside on the patio. The CNA stated earlier resident 1 was assisted back to bed and after attending to another resident and returning to Resident 1's room, Resident 1 was not in bed. The CN and CNA assisted resident up from the ground and