STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Del Rio	7002 Gage Avenue Bell Gardens, CA 90201

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900 Based on interview and record review, the facility failed to develop and implement a plan of care for a resident that was at risk of elopement (the act of leaving a facility unsupervised and without prior authorization) for one of two residents (Resident 1). This deficient practice had the potential to delay the delivery of necessary care and services to minizine the risk of elopement. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 1 had serious mental illness and severely impaired cognitive skills for daily decision making (ability to think, remember and reason). The MDS indicated Resident 1 had wandering behavior. The MDS indicated Resident 1 was independent (resident completed the activity by himself without assistance from a helper) with eating and oral hygiene. The MDS indicated Resident 1 required supervision with toileting hygiene and personal hygiene. During a review of Resident 1's Order Summary Report as of 1/16/2025, the report indicated an order, dated 1/8/2025, to monitor Resident 1's episodes of seeking exit doors behavior every shift. During a review of Resident 1's Elopement Risk Evaluation (ERE), dated 1/8/2025, the form indicated Resident 1 was at risk of elopement. The form indicated Resident 1 had a history of elopement or an attempted elopement while at home. The form further indicated Resident 1 had a history of attempting to leave the facility without informing staff. During a review of Resident 1's Multidisciplinary Care Conference, dated 1/8/2025, the form indicated Resident 1 had episodes of forgetfulness and confusion. The form indicated Resident 1 remained in a secured facility (designed to physically restrict the movements and activities of persons)and ambulated (to walk or move from one place to another) throughout the nursing unit without assistance. (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: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Villa Del Rio		STREET ADDRESS, CITY, STATE, ZIP CODE 7002 Gage Avenue Bell Gardens, CA 90201	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Incident Report, dated 1/15/2025, the report indicated Resident 1 was missing from the facility at 12:00 p.m. During a concurrent record review and interview on 1/16/2025 at 1:48 p.m. with the MDS-Licensed Vocational Nurse (MDS-LVN), Resident 1's care plans as of 1/16/2025 were reviewed, the MDS-LVN stated there was no care plan for Resident 1's risk for elopement. The MDS-LVN stated Resident 1 should have a at risk care plan for elopement so staff could have a plan to prevent or to minimize the resident's risk of elopement. The MDS-LVN stated the potential risk for not having the at risk of elopement care plan was an actual elopement. The MDS-LVN stated the purpose of a care plan was to capture any possible conditions that could affect the residents while residing in the facility, and to implement a plan of care. The MDS-LVN stated the MDS nurse was responsible for initiating the care plan within seven days of admission. During a concurrent record review and interview on 1/16/2025 at 2:07 p.m. with the Director of Nursing (DON), Resident 1's ERE, dated 1/8/2025, was reviewed. The DON stated the ERE indicated Resident 1 was at risk of elopement, and the facility should have a care plan addressing Resident 1's risk of elopement. The DON stated they identified resident's with elopement risk from the elopement/wandering assessment. The DON stated the purpose of the care plan was to ensure interventions for the resident's safety based on individual's needs. The DON stated the potential risk was actual elopement. During a review of the facility's Policy and Procedure (P&P), titled, Care Plans, Comprehensive (complete, thorough, or including all or nearly all aspects of something), undated, the P&P indicated resident's comprehensive care plan was designed to incorporate risk factors associated with identified problems and aid in preventing or reducing declines in the resident's functional status and/ or functional levels. The P&P further indicated the resident's comprehensive care plan was developed within seven days of the completion of the resident's MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Villa Del Rio		STREET ADDRESS, CITY, STATE, ZIP CODE 7002 Gage Avenue Bell Gardens, CA 90201	

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** 49900 Based on interview and record review, the facility failed to provide adequate supervision for one of two residents (Resident 1) who were at risk of elopement (the act of leaving a facility unsupervised and without prior authorization) when Resident 1 eloped from the facility on 1/15/2025. This deficient practice had the potential to negatively affect Resident 1's physical, mental, and psychosocial well-being. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN- high blood pressure), and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 1 had serious mental illness and severely impaired cognitive skills for daily decision making (ability to think, remember and reason). The MDS indicated Resident 1 had wandering behavior. The MDS indicated Resident 1 was independent (resident completed the activity by himself without assistance from a helper) with eating and oral hygiene. The MDS indicated Resident 1 required supervision with toileting hygiene and personal hygiene. During a review of Resident 1's Order Summary Report as of 1/16/2025, the report indicated an order, dated 1/8/2025, to monitor Resident 1's episodes of seeking exit doors behavior every shift. During a review of Resident 1's Elopement Risk Evaluation (ERE), dated 1/8/2025, the form indicated Resident 1 was at risk of elopement. The form indicated Resident 1 had a history of elopement or an attempted elopement while at home. The form further indicated Resident 1 had a history of attempting to leave the facility without informing staff. During a review of Resident 1's Multidisciplinary Care Conference, dated 1/8/2025, the form indicated Resident 1 had episodes of forgetfulness and confusion. The form indicated Resident 1 remained in a secured facility (designed to physically restrict the movements and activities of persons) and ambulated (to walk or move from one place to another) throughout the nursing unit without assistance. During a review of Resident 1's Incident Report, dated 1/15/2025, the report indicated Resident 1 was missing from the facility at 12:00 p.m. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555781	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Villa Del Rio		STREET ADDRESS, CITY, STATE, ZIP CODE 7002 Gage Avenue Bell Gardens, CA 90201	

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	During an interview on 1/16/2025 at 11:34 a.m. with Certified Nurse Assistance (CNA) 2, CNA 2 stated she was the assigned CNA for Resident 1 on 1/15/2025. CNA 2 stated she last saw Resident 1 in the activity room before her break, and she was unable to locate Resident 1 around 12 p.m. after she assisted other residents back to their rooms for lunch. CNA 2 stated she was aware of Resident 1's behavior of visiting other residents in the facility, but she was not aware that Resident 1 was at risk of elopement. CNA 2 stated she would have checked up more on Resident 1 if she knew Resident 1 was at risk of elopement. During an interview on 1/16/2025 at 1:08 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she last saw Resident 1 in his room around 11 a.m. on 1/15/2025 and could not locate Resident 1 anywhere in the facility around 12 p.m. LVN 1 stated she was not aware that Resident 1 was at risk of elopement because Resident 1 did not have any behaviors of exit seeking exit door nor did the resident express he wanted to leave the facility. LVN 1 stated she was aware of Resident 1's diagnosis of dementia and ability to ambulate around the facility. LVN 1 stated the precaution for dementia care was to stay close with to the resident to observe changes and orient the resident. LVN 1 stated staff should ensure resident's safety by staying close to the residents and providing one on one (1:1, a situation where a dedicated healthcare professional constantly observed and attended to a single resident, maintaining close proximity at all times to ensure their safety and intervene as needed) supervision with residents who are at risk of elopement. During a concurrent record review and interview on 1/16/2025 at 2:07 p.m. with the Director of Nursing (DON), Resident 1's ERE, dated 1/8/2025, was reviewed. The DON stated the ERE indicated Resident 1 was at risk of elopement. The DON stated licensed nurses informed the CNAs about the residents at risk of elopement during huddle (a short meeting where nurses and other healthcare professionals discussed resident safety, quality, and efficiency). The DON stated the facility wasnot aware of Resident 1's elopement risk, because they did not notice any door seeking behavior nor received report from the previous facility regarding Resident 1's behavior. The DON stated Resident 1's elopement was caused by lack of supervision, and all staff were responsible to supervise residents. During a review of the facility's Policy and Procedure (P&P), titled Elopements and wandering residents, undated, the P&P indicated Monitoring and managing residents at risk for elopement or unsafe wandering: Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. During a review of the facility's P&P, titled Safety and supervision of residents, undated, the P&P indicated Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The care team shall target interventions to reduce the potential for accidents. 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.