STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555781	A. Building B. Wing	05/27/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure (P&P) for discharge against medical advice (AMA) for one of one sampled resident (Resident 1) when Resident 1 left the faciity on 5/22/2026. This deficient practice had the potential to place Resident 1 at risk for unmet care needs, continuum of care, and adverse health outcomes. 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 schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of fear and dread), and epilepsy (a neurological \disorder characterized by recurrent, unprovoked seizure). During a review of Resident 1's record titled Social Services History and Initial Assessment, dated 5/19/2026, the record indicated Resident 1 had the ability to understand and be understood by others. The record indicated Resident 1's cognition (the ability to think and process information) was intact. During a review of Resident 1's care plan titled Activities of Daily Living (ADLs), dated 5/19/2026, the care plan indicated Resident 1 required supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's progress note, dated 5/22/2026 and timed at 6:54 p.m., the progress note indicated on 5/22/2026 at approximately 5:00 p.m., Resident 1 was nowhere to be found within the facility. The progress note indicated staff implemented a search inside and outside of the facility. The progress indicated the Administrator (ADM) and the Director of Nursing (DON) were notified. During a review of Resident 1's Incident Report dated 5/26/2026, the incident report indicated Resident 1 verbalized an intent to leave the facility. The incident report indicated Resident 1 left the facility against medical advice (AMA) on 5/22/2026. The incident report did not include documented evidence that staff followed the facility's AMA discharge policy, including physician notification, AMA risk education, a signed AMA form, discharge instructions, or documentation of the resident's understanding of risks of leaving the facility AMA. During an interview on 5/27/2026 at 11:00 a.m., with Registered Nurse (RN) 1, RN 1 stated on 5/22/2026 at 7:06 p.m., Licensed Vocational Nurse (LVN)1 notified her that Resident 1 left the facility AMA on 5/22/2026 at approximately 4:45 p.m. RN 1 stated staff were expected to follow the facility's AMA discharge policy when a resident requested to leave AMA. RN 1 stated this included notifying the physician, explaining the risk of leaving AMA, completing the AMA form, documenting the resident's decision, and providing discharge instructions. RN 1 stated the required AMA discharge process was not completed for Resident 1. During an interview on 5/27/2026 at 3:45 p.m., with LVN 1, LVN 1 stated on 5/22/2026 at approximately 4:30 p.m., she observed Resident 1 agitated and pacing back and forth in the television room. LVN 1 stated she notified Resident 1's physician regarding the resident's behavior. LVN 1 stated she did not recall Resident 1 requesting to leave the facility on 5/22/2026 because she did not speak with the resident while he was in the television room. LVN 1 stated that during staff rounds on 5/22/2026 at approximately 5:00 p.m., Certified Nursing Assistant (CNA) 1 notified her that Resident 1 was nowhere to be found. LVN 1 stated she was unsure how Resident 1 left the facility. LVN 1 stated the AMA discharge process was not completed before Resident 1 left the facility. During a concurrent interview and record review on (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
	555781	A. Building B. Wing	05/27/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/27/2026 at 4:45 p.m., with the ADM, the facility's policy and procedure (P&P) titled Transfer and Discharge, dated 2026, was reviewed. The P&P indicated when a resident expresses their wishes to be discharged earlier than outlined in the care plan, AMA applies. The P&P indicated the resident should be informed of the risks involved, the benefits of staying at the facility and alternatives to leaving. The P&P indicated the physician should be notified of the intended AMA discharge and the notification should be documented in the nurse's notes by the nursing department. The P&P also indicated social services should document any discussions held with the resident in the social services progress notes. The ADM stated the required AMA discharge process was not completed for Resident 1. The ADM stated the facility should have followed its AMA discharge policy but did not. The ADM stated the facility failed to follow its AMA discharge policy when Resident 1 left the faciity on 5/22/2026. The ADM stated the facility failed to complete the required AMA discharge process as required per facility policy.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 accurately and timely documented a resident's aggressive behavior for one of three sampled Residents (Resident 1). This deficient practice had the potential to result in incomplete communication among staff regarding Resident 1's behavior status, delayed assessment, and the provision of care and/or interventions for the resident.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 schizophrenia (a mental illness that is characterized by disturbances in thought), anxiety (a feeling of fear and dread), and epilepsy (a neurological disorder characterized by recurrent, unprovoked seizure). During a review of Resident 1's record titled Social Services History and Initial Assessment, dated 5/19/2026, the record indicated Resident 1 had the ability to understand and be understood by others. The clinical record indicated Resident 1's cognition (the ability to think and process information) was intact. During a review of Resident 1's progress note, authored by Licensed Vocational Nurse (LVN) 1, dated 5/26/2026, the progress note indicated on 5/22/2025 at 4:32 p.m., Resident 1 was observed pacing back and forth in the television room. When approached resident became verbally aggressive towards staff. Attempted to redirect resident to room but resident continued to show agitation. During a concurrent observation and interview on 5/27/2026 at 12:55 p.m., with the Administrator (ADM), the facility's video surveillance footage, dated 5/22/2026, from 3:30 p.m. to 3:50 p.m., was reviewed. The video surveillance footage revealed Resident 1 was observed standing in the television room. Resident 1 was not exhibiting aggressive behavior. The footage did not show Resident 1 yelling, striking, threatening, or attempting to physically harm any resident or staff. The footage also indicated there was no staff present in the television room. The ADM stated the video surveillance footage did not show Resident 1 displaying aggressive behaviors and did show staff present in the television room on 5/22/2026 between 3:30 p.m. and 3:50 p.m. The ADM stated the video footage did not support LVN 1's documentation that Resident 1 exhibited aggressive behaviors on 5/22/2026. During a concurrent interview and record review on 5/27/2026 at 3:30 p.m., with LVN 1, Resident 1's progress note, dated 5/26/2026 timed 6:23 p.m., was reviewed. The progress note indicated Resident 1 exhibited aggressive behaviors on 5/22/2026 at 4:32 p.m LVN 1 stated the progress note was not documented at the time of the alleged event and was documented four days later, on 5/26/2026. LVN 1 stated the event should have been documented timely and accurately in Resident 1's medical record to ensure the record reflected the resident's current condition, behaviors, and interventions provided. LVN 1 stated delayed documentation could affect the accuracy and completeness of Resident 1's clinical record. During an interview on 5/27/2026 at 4:35 p.m., with the Director of Nursing (DON), the DON stated staff were expected to document resident behaviors, incidents, assessments, and interventions timely and accurately in the resident's medical record. The DON stated documentation should be completed at or near the time the event occurred to ensure the medical record reflected the resident's current condition and the care provided. The DON stated late documentation may affect the accuracy and completeness of the resident's clinical record. The DON stated Resident 1's progress note, dated 5/26/2026 and timed 6:23 p.m., regarding Resident 1's alleged aggressive behavior on 5/22/2026, was not documented timely. The DON stated Resident 1's medical record should contain accurate information supported by the resident's condition, staff observations, and interventions provided. During a review of the facility's P&P titled Charting and Documentation, reviewed 2026, the P&P indicated all incidents, accidents, or changes in resident's condition must be timely recorded in their medical record.