STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055060	A. BUILDING _____ B. WING _____	**10/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY VILLA WESTWOOD	**12121 SANTA MONICA BOULEVARD LOS ANGELES, CA 90025**

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe environment for Resident 1 (R1) who required staff supervision due to her severely impaired mental status and had a high risk for wandering out of and away from the facility. This deficient practice resulted in R1 wandering out of the facility through an unlocked gate and onto a busy street where she could have been injured and could have resulted in death. Findings: A review of R1's Facesheet, dated 8/5/20, indicated the facility admitted R1's on 1/23/20, with a [DIAGNOSES REDACTED]. A review of R1's History and Physical written by MD1, dated 1/24/20, indicated, R1 had a medical history of [REDACTED]. A review of R1's Minimum Data Set (a tool for resident assessment) dated 4/30/20, indicated the facility documented the mental status of R1's as, Severely Impaired. A review of R1's Elopement Risk Assessment, dated 8/3/20, indicated the facility assessed and documented R1 to be at Risk/or Potential Elopement from the Facility. A review of R1's Resident Care Plan for Wandering/Elopement dated 1/24/20, indicated, .Resident is a risk for wandering or elopement related to: . cognitive status (ability to think clearly) . unfamiliarity with new environment . Sensory Impairment (a lack of awareness of a person's surroundings) . Resident is unaware of safety needs . A review of R1's of SBAR Communication Form - Change of Condition Progress Note, dated 8/4/20, indicated, the facility notified MD1 that the staff could not find R1 in or around the facility and did not know the current location of R1. A review of R1's Nurse's Notes, dated 8/4/20, indicated, the facility staff began looking for R1 at 2:30 pm on 8/4/20 and notified the Administrator (ADM), Director of Nursing (DON), R1's Primary Physician, 911, and R1's Responsible Party (Family1) that R1 was missing and that Police arrived and the facility gave the Police a description of R1. A review of R1's Social Service Progress Notes, dated 8/4/20 at 5:02 PM, indicated, the Social Services Department became aware that R1 was missing at 3:00 pm on 8/4/20 and searched inside and outside of the facility for R1, ADM contacted the police and filed a missing person's report and the SSD informed Family1 that R1 was missing. A review of R1's Health Status Note, dated 8/4/20 at 9:00 PM, indicated, Police and paramedics brought R1 back to the facility around 8:20 pm on 8/4/20, Family1 was at the facility when R1 returned to the facility, the facility informed MD2 that R1 had returned to the facility and MD2 ordered the facility to transfer R1 to a hospital for further evaluation. R1's Health Status Note, dated 8/4/20 at 9:00 PM also indicated that the facility staff assessed R1 and documented her condition as, awake and verbally responsive; No complain of pain and no signs of pain documented. No shortness of breath . During an observation on 9/6/20, at 10:00 am, there is a gate that can allow access to the facility patio, from the sidewalk outside the facility, which is closed and locked with a padlock. The gate does not open when pushed or shaken. During an observation and a concurrent interview with the ADM, on 8/6/20 at 11:45 pm, the patio of the facility is walled in all four sides, however there is a gate that opens onto the sidewalk outside the facility, which is closed and locked with a padlock. The gate does not open when pushed or shaken. ADM stated that normally the gate is locked with the padlock, but he assumes that a staff member unlocked the padlock on the day that R1 left the facility without supervision and did not re-lock the padlock after they had moved through the gate. A review of a letter written by the ADM, addressed to The Department dated 8/5/20, indicated, The last facility employee with the recollection of seeing R1 stated she was in the facility at approximately 14:30. The last facility resident with the memory of seeing R1 stated she was walking about the facility patio at approximately 14:30, shortly after the facility employee documented seeing R1. There are no witnesses of R1 leaving the facility patio. However, the resident that witnessed her walking about the patio stated he saw her go towards the gate leading out of the facility and then did not see her return. Two staff members documented at the onset of the search that the patio gate was ajar. Based on these statements, it can be inferred that R1 left facility property sometime between 2:30 PM and 3:00 PM through the patio gate. During an interview with the ADM, on 8/6/20 at 11:30 AM, the ADM stated R1 was documented by the facility staff as missing on 8/4/20, at about 3:00 pm. The ADM stated a staff member reported seeing R1 on the facility patio, which has a gate that opens to the side walk outside the facility, prior to 3:00 pm. The ADM further stated the patio gate is usually and supposed to be locked with a padlock at all times. On the day that the staff documented R1 to be missing, the staff found the patio gate that opens to the sidewalk outside the facility, to be ajar and without the padlock in the locked position. The ADM further stated the facility assumes that R1 left the facility via the unlocked patio gate. The ADM further stated the facility patio gate not being locked at all times is dangerous because a resident can leave the facility without supervision and wander into a street and be hit by a car, assaulted by another person, fall and sustain an injury and not been able to find their way back due to mental impairment. During an interview with the DON, on 8/6/20, at 11:32 AM, the DON stated the facility patio gate not being locked at all times is dangerous because a resident can leave the facility without supervision and wander into a street and be hit by a car, assaulted by another person, fall and sustain an injury and not be able to find their way back due to mental impairment. During an observation and a concurrent interview with the ADM, on 8/6/20 at 11:45 pm, the ADM stated the patio of the facility is walled in all four sides, however there is a gate that opens onto the sidewalk outside the facility, which is closed and locked with a padlock. The gate does not open when pushed or shaken. The ADM further stated that normally the gate is locked with the padlock. The ADM assumes that a staff member unlocked the padlock on the day that R1 left the facility without supervision and did not re-lock the padlock after they had moved through the gate. The facility's policy and procedures titled, Elopement Risk Reduction Approaches, with revised date of Nov. 2012, indicated, The facility staff needs to know: (iv) The consequences of undsafe wandering, the protocols to follow to minimize successful exiting and the procedures to follow when a resident is lost.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.