STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055104	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Conv Hosp	2720 Nevada Avenue El Monte, CA 91733

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40037 Based on observation, interview, and record review, the facility failed to provide a safe environment as indicated in the facility's policies and procedures (P&P) titled, Preventive Maintenance Program, and Safe and Homelike Environment, for one of three sampled residents (Resident 1) by failing to: 1. Ensure the Maintenance Director (TMD) had a schedule of maintenance services for Resident 1's bed remote control coil line (coiled remote-control cord). 2. Ensure Certified Nurse Assistant 2 (CNA 2) prevented Resident 1 from grabbing onto Resident 1's damaged/broken bed remote control coil hanging on Resident 1's right bed side rail (an adjustable bar attached to a bed to help patients/residents move around) during care. As a result, on 12/17/2024 at 5 am, Resident 1 sustained a laceration (a wound when skin, tissue, and/or muscle was torn or cut open) on Resident 1's inner right hand between the thumb and index finger (also known as the pointer finger, or first finger) measuring 2 centimeters (cm-unit of measurement) in length, by 0. 2 cm in width and by 0.2 in depth. Resident 1 was transferred to General Acute Care Hospital 1 (GACH 1) on 12/17/2024 at 10:45 am and required seven surgical sutures (stitches, length of thread used to join up pieces of tissue) for wound closure. Resident 1 had six stitches (a medical procedure that uses thread and a needle to close wounds) along the right thumb with ragged edges and one stitch on the base of the index finger with skin tear (a traumatic wound that occurs when the skin's layers separate). Cross Reference: F908 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/29/2024 with diagnoses that included type II Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a condition when the heart is not able to pump enough blood and oxygen to the body's organs) and respiratory failure (a condition when the lungs cannot get enough oxygen into the blood). (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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(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 - Actual harm Residents Affected - Few	During a review of Resident 1's History and Physical (H&P, a formal and complete assessment of the resident by a physician) dated 9/17/2024, the H&P indicated Resident 1 was non-verbal and did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 12/3/2024, the MDS indicated Resident 1 had unclear speech and severely impaired cognition (thinking, reasoning, or remembering for daily decision making). The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting, showering, dressing and chair/bed-to-chair transfers. During a review of Resident 1's Progress Notes (PN), dated 12/17/2024, timed at 5 am, the PN indicated Resident 1 sustained an inner right-hand cut (laceration) when Resident 1 held onto the right bed side rail while being cleaned and turned by CNA 2. During a review of Resident 1's PN, dated 12/17/2024, timed at 5:46 am, the PN indicated Resident 1 had an open cut/wound on the inner right hand. The PN indicated Resident 1's right hand wound was acquired in the facility and measured 2 cm in length by 0.2 cm in width and 0.2 cm in depth. During a review of Resident 1's Physician's Order (PO) dated 12/17/2024 (untimed), the PO indicated to transfer Resident 1 to GACH 1 due to right hand cut. During a review of Resident 1's PN dated 12/17/2024, timed at 10:45 am, the PN indicated Resident 1 was transferred to GACH 1 due to a cut on the right hand. During a review of GACH 1's Emergency Department Note (EDN) dated 12/17/2024, the EDN indicated Resident 1 had a right-hand laceration and received laceration repair. The EDN indicated Resident 1's right hand laceration was closed with seven stitches. During a review of Resident 1's PN dated 12/17/2024, timed at 6:20 pm, the PN indicated Resident 1 was readmitted back to the facility from GACH 1 after treatment of Resident 1's laceration to the right palm (the grasping side of the hand) of the hand. The PN indicated Resident 1 had six stitches along the right thumb with ragged edges and one stitch on the base of the index finger with skin tear. During an observation of Resident 1's right hand in Resident 1's room on 1/3/2025 at 11:24 am, Resident 1 was lying in bed with eyes closed. Resident 1's right hand was wrapped with dry bandage roll (a long, rolled-up piece of absorbent material used to cover wounds, apply pressure, and secure dressings). (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation of Resident 1's right palm, in Resident 1's room and concurrent interview with Licensed Vocational Nurse 1 (LVN 1) on 1/3/2025 at 11:29 am, Resident 1's right palm had seven stitches between the thumb and the index finger. LVN 1 stated, Resident 1 was sent to GACH 1 on 12/17/2024 due to a cut to the right hand from Resident 1's bed remote control coil line. LVN 1 stated, the outer hard plastic layer of Resident 1's bed remote control coil line was broken, and part of the coil was pointing out. LVN 1 stated, when CNA 2 turned and repositioned Resident 1, Resident 1 grabbed onto the sharp broken part (plastic) of the bed remote control coil line, and Resident 1 sustained a laceration of Resident 1's right hand/palm. LVN 1 stated, staff (in general) need to ensure Resident 1's equipment was in good condition to prevent injury to Resident 1. LVN 1 stated, maintenance staff need to routinely check all devices and equipment to ensure the equipment and devices were in good condition and working properly for resident's safety. During an interview with the Maintenance Assistant (MA) on 1/3/2025 at 12 pm, the MA stated, the MA did an investigation on 12/17/2024 after Resident 1 sustained a right-hand laceration. The MA stated, Resident 1's bed remote control coil line was broken. The MA stated the inside of the electric wire was exposed, and the outer layer/hard plastic was peeled off, forming a sharp pointed edge. The MA stated, there was blood stain on the broken part of Resident 1's bed remote control coil. The MA stated, checking the bed remote control was not part of the Maintenance Department's routine task since MA started working at the facility nine months ago. The MA stated, the Maintenance Department would only check the bed remote control upon request. The MA stated, checking the bed remote control was added to the Maintenance Department's routine task after the incident with Resident 1, who sustained a laceration of the inner right hand on 12/17/2024. The MA stated, it was important to check all resident's equipment routinely including the bed remote control to ensure resident's safety and to prevent injury to the residents. The MA stated, if the Maintenance Department performed a routine check and found the broken bed control coil line earlier, Resident 1's injury could have been prevented. During a concurrent review of Resident 1's Interdisciplinary Team (IDT, a group of healthcare professionals who work together to provide patient care), Progress Note dated 12/17/2024, timed at 2:27 pm, and an interview with the facility's Director of Nursing (DON) on 1/3/2025 at 1:17 pm, the IDT Progress Note indicated on 12/17/2024 around 5 am, Resident 1 was being turned and changed by CNA 2 and CNA 2 saw Resident 1 holding onto the siderail on the right side of the bed with bloody open cut in the inner right hand between Resident 1's thumb and index finger. The IDT Progress Note indicated Resident 1's bed control coil line was damaged with the hard plastic sticking out. The DON stated Resident 1 grabbed onto Resident 1's damaged/broken bed coil line and sustained an injury on Resident 1 right hand. The DON stated, it was important to routinely check all medical devices and equipment and to keep them in good condition for resident's safety. The DON stated, Resident 1's injury (laceration to the right inner hand) could be avoided if the facility maintained its equipment in good condition. During an interview with the facility's Administrator (ADM) on 1/3/2025 at 3:01 pm, the ADM stated CNA 2 was terminated. The ADM and Surveyor 1 called CNA 2 for a telephone interview and CNA 2 did not answer the phone call. During a review of the facility's P&P titled, Safe and Homelike Environment, dated 12/19/2022, the P&P indicated The facility will provide a safe, clean, comfortable, and homelike environment. The P&P indicated This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled, Preventive Maintenance Program, dated 12/19/2022, the P&P indicated A preventive maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The P&P indicated The maintenance director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 40037 Based on observation, interview, and recorded review, the facility failed to maintain the resident's bed remote control coil line (coiled remote-control cord) in safe operating condition for one of three sampled residents (Resident 1). The hard plastic covering of Resident 1's bed remote control coil line was damaged and pointed out. This failure resulted in a laceration (a wound when skin, tissue, and/or muscle was torn or cut open) on Resident 1's inner right hand between the thumb and index finger (also known as the pointer finger, or first finger) measuring 2 centimeters (cm-unit of measurement) in length, by 0.2 cm in width and by 0.2 in depth. Cross Reference : F689 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/29/2024 with diagnoses that included type II Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a condition when the heart is not able to pump enough blood and oxygen to the body's organs) and respiratory failure (a condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 1's History and Physical (H&P, a formal and complete assessment of the resident by a physician) dated 9/17/2024, the H&P indicated Resident 1 was non-verbal and did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 12/3/2024, the MDS indicated Resident 1 had unclear speech and severely impaired cognition (thinking, reasoning, or remembering for daily decision making). The MDS indicated Resident 1 was dependent (helper does all the effort, resident does none of the effort to complete the activity) for toileting, showering, dressing and chair/bed-to-chair transfers. During an observation of Resident 1's right palm, in Resident 1's room and concurrent interview with Licensed Vocational Nurse 1 (LVN 1) on 1/3/2025 at 11:29 am, Resident 1's right palm had seven stitches between the thumb and the index finger. LVN 1 stated, Resident 1 was sent to GACH 1 on 12/17/2024 due to a cut to the right hand from Resident 1's bed remote control coil line. LVN 1 stated, the outer hard plastic layer of Resident 1's bed remote control coil line was broken, and part of the coil was pointing out. LVN 1 stated, when CNA 2 turned and repositioned Resident 1, Resident 1 grabbed onto the sharp broken part (plastic) of the bed remote control coil line, and Resident 1 sustained a laceration of Resident 1's right hand/palm. LVN 1 stated, staff (in general) need to ensure Resident 1's equipment was in good condition to prevent injury to Resident 1. LVN 1 stated, maintenance staff need to routinely check all devices and equipment to ensure the equipment and devices were in good condition and working properly for resident's safety. (continued on next page)

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Maintenance Assistant (MA) on 1/3/2025 at 12 pm, the MA stated, the MA did an investigation on 12/17/2024 after Resident 1 sustained a right-hand laceration. The MA stated, Resident 1's bed remote control coil line was broken. The MA stated the inside of the electric wire was exposed, and the outer layer/hard plastic was peeled off, forming a sharp pointed edge. The MA stated, there was blood stain on the broken part of Resident 1's bed remote control coil. The MA stated, checking the bed remote control was not part of the Maintenance Department's routine task since MA started working at the facility nine months ago and the Maintenance Department would only check the bed remote control upon request. The MA stated, checking the bed remote control was added to the Maintenance Department's routine task after the incident with Resident 1, who sustained a laceration of the inner right hand on 12/17/2024. The MA stated it was important to check all resident's equipment routinely including the bed remote control to ensure resident's safety and to prevent injury to the residents. The MA stated, if the Maintenance Department performed a routine check and found the broken bed control coil line earlier, Resident 1's injury could have been prevented. During an interview with the facility's Director of Nursing (DON) on 1/3/2025 at 1:17 pm, the DON stated, it was important to routinely check all medical devices and equipment and to keep them in good condition for resident's safety. The DON stated, Resident 1's injury (laceration to the right inner hand) could be avoided if the facility maintained its equipment in good condition. During a review of the facility's P&P titled, Preventive Maintenance Program, dated 12/19/2022, the P&P indicated A preventive maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The P&P indicated The maintenance director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.