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	11/20/2025

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 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. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure the nursing staff implemented person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for one of two sampled residents (Resident 2) by failing to monitor Resident 2's symptoms of increased confusion/physical abusive towards staff. These deficient practices had the potential to place Resident 2 at risk of not receiving the individualized care services to attain or maintain highest practicable physical, mental, and psychosocial well-being.Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to facility on 2/17/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one-sided muscle weakness) following nontraumatic intracerebral hemorrhage (bleeding within the brain, most commonly due to high blood pressure, trauma, or other blood vessel issues) affecting left non-dominant side, acute kidney failure (rapid loss of kidney function, where the kidneys can no longer effectively filter waste, balance fluids, and maintain electrolytes), and neuromuscular dysfunction of bladder (occurs when nerve damage disrupts communication between the brain and the bladder, leading to symptoms like loss of bladder control, frequent urination, or difficulty emptying the bladder). During a review of Resident 2's History and Physical (H&P), dated 2/20/2025, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 8/22/2025, the MDS indicated Resident 2 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, and personal hygiene. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing. During a review of Resident 2's Care Plan Report(CP), initiated on 9/5/2025, the CP indicated Resident 2 had increased confusion/physical abusive towards staff, and the facility will monitor resident for worsening of symptoms. During a concurrent interview and record review on 11/20/2025 at 11:38 AM with the Registered Nurse (RN) 2, Resident 2's Medication Administration Record (MAR), Monitoring Record (MR), and CP for September, October, and November 2025 were reviewed. RN 2 stated there was no documentation to indicate the implementation of the CP, such as monitoring Resident 2 for worsening symptoms. RN 2 stated Resident 2 should be monitored according to the CP to improve the resident's safety and well-being. During a concurrent interview and record review on 11/20/2025 at 1:28 PM with the Licensed Vocational Nurse (LVN) 3, Resident 2's MAR, MR, and CP for September, October, and November 2025 were reviewed. LVN 3 stated there was no monitoring record for Resident 2, and the staff should have monitored Resident 2's symptoms of confusion/physical abusive towards staff to implement the CP. During a concurrent interview and record review on 11/20/2025 at 1:37 PM with the Director of Nursing (DON), Resident 2's MAR, MR, and CP for September, October, and November 2025 were reviewed. The DON stated that the facility did not monitor Resident 2's symptoms of confusion/physical abusive towards staff according to the interventions indicated in the resident's CP. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Care Plans, implemented on 12/19/2022 and revised on 1/31/2025, the P&P indicated that the facility should develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P indicated, Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure the licensed nurse implemented the facility's Policy and Procedure (P&P) titled Medication Orders by failing to indicate the severity of the pain level for the pain medication order for one of two sampled residents (Resident 1). This deficient practice had the potential to place Resident 1 at risk of not receiving the optimal therapeutic effect (desirable and beneficial effects resulting from a medical treatment) of the medication, which had the potential to impair Resident 1's wellbeing.Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to facility on 8/15/2025 with diagnoses including hemiplegia (total paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following cerebral infarction (as a result of disrupted blood flow to the brain due to problems with the blood vessels) affecting left non-dominant side, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (a type of nerve damage that can happen with diabetes), and aphasia (a disorder that makes it difficult to speak) following cerebral infarction.During a review of Resident 1's History and Physical (H&P) dated 8/16/2025, the H&P indicated Resident 1 could not make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 8/18/2025, the MDS indicated Resident 1 had severely impaired cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for oral hygiene, bathing, upper body dressing, personal hygiene, and toileting hygiene. During a review of Resident 1's Order Summary Report (OSR), dated 11/19/2025, the OSR indicated Resident 1 had a medication order for hydrocodone-acetaminophen (medication to relieve pain) oral tablet 5-325 milligrams (mg-measuring unit), one tablet via (through) the gastrostomy tube (G-Tube, a surgical opening fitted with a device to allow feedings/medications administered directly into the stomach) every four hours as needed for pain, with order start date of 11/3/2025. During a concurrent interview and record review on 11/20/2025 at 11:38 AM with Registered Nurse 2 (RN 2), Resident 1's Medication Administration Record (MAR) and OSR for November 2025 were reviewed. The MAR indicated Resident 1 was administered hydrocodone-acetaminophen 5-325 mg via G-Tube for pain levels ranging from 4 to 9 on a 0 to 10 pain scale rating (a numerical rating scale, which 0 equals to no pain, 10 equals to the worst pain possible; 1-3 mild pain, 4-6 moderate pain and 7-10 severe pain) on several days. RN 2 stated Resident 1's order for hydrocodone-acetaminophen did not indicate to administer the pain medication based on pain level by using a numerical scale but the MAR indicated the licensed nurse administered hydrocodone-acetaminophen to Resident 1 based on pain level of 4 to 9. RN 2 stated Resident 1's order for hydrocodone-acetaminophen should have been clarified by the licensed nurse with Resident 1's physician to indicate hydrocodone-acetaminophen was for moderate and/or severe pain. During a concurrent interview and record review on 11/20/2025 at 1:28 PM with Licensed Vocational Nurse 3 (LVN 3), Resident 1's MAR and OSR for November 2025 were reviewed. LVN 3 stated the licensed nurse who entered the order for Resident 1's hydrocodone-acetaminophen should have indicated the pain medication was for moderate or severe pain. During a concurrent interview and record review on 11/20/2025 at 1:37 PM with the Director of Nursing (DON), Resident 1's MAR and OSR for November 2025 were reviewed. The DON stated the licensed nurse failed to enter the hydrocodone-acetaminophen medication order correctly for Resident 1. The DON stated the order for hydrocodone-acetaminophen for Resident 1 should be clarified with the physician and entered with indication for moderate and/or severe pain for Resident 1. The DON stated it was important for the nurses to enter the order accurately. During a review of the facility's P&P titled, Medication Orders, revised 1/31/2025, the P&P indicated, Elements of the Medication Order:i. Diagnosis or indication for use.j. PRN (as needed) orders should also specify the condition for which they are being administered, (e.g., as needed for sleep).The P&P indicated, Documentation of Medication Orders:b. Clarify the order. During a review of the facility's P&P titled, Pain Management, revised 3/17/2025, the P&P indicated the facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. The P&P indicated the facility would ask the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident. The P&P indicated factors influencing the choice of treatments include:a. The cause, location and severity of resident's pain .P&P indicated pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain, general principles the facility will utilize for prescribing analgesics:a