

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER Sunset Manor Conv Hosp		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement the care plan for one of three sampled residents (Resident 1) by failing to ensure Resident 1 did not have clutter around Resident 1's bed. This deficient practice placed Resident 1 at risk for falls and injuries from excessive clutter surrounding Resident 1's bed. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was initially admitted to the facility on [DATE] with diagnoses that included COPD (Chronic obstructive pulmonary disease, a chronic lung disease causing difficulty in breathing), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can interfere with daily functioning), and depression (a persistent sadness, loss of interest in activities, and low energy, severely impacting daily life). During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated [DATE], the H&P indicated Resident 1 had minor memory impairments but had the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 1's cognitive skills (ability to make daily decisions) was intact. The MDS also indicated Resident 1 was independent (completed activity with no assistance with helper) with activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily) and with mobility and walking. During a review of Resident 1's Social Services Notes (SSN), dated [DATE], the SSN indicated Resident 1 was educated about how too much clutter around her bed posed a safety hazard to both Resident 1 and Resident 1's roommates. The SSN also indicated Resident 1 refused to allow the facility to store Resident 1's belongings in an alternate location instead of at the bedside. During a review of Resident 1's medical record, there were no other notes from [DATE] to [DATE] regarding assisting or encouraging Resident 1 to remove the clutter from Resident 1's room. During a review of Resident 1's Care Plan Report (CPR), initiated on [DATE], the CPR indicated Resident 1 was at risk for falls due to incontinence (lack of voluntary control over urination and/or bowel movement) and history of falls. The CPR interventions included providing Resident 1 a safe environment free from spills and/or clutter. During a review of Resident 1's CPR, initiated on [DATE], the CPR indicated Resident 1 had a behavior problem of hoarding (a mental health condition marked by a persistent inability to discard possessions, leading to excessive accumulation that clutters living spaces, disrupts daily life, and causes distress) related to anxiety and depression. The CPR interventions included for the Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care) to follow up with Resident 1 regarding hoarding behavior and intervening as necessary to protect the rights and safety of others. The CPR indicated there had been no updates or changes to the CPR since it was initiated on [DATE]. During an observation on [DATE] at 2 pm, in Resident 1's room, Resident 1's bed was surrounded by stacked up boxes, crates, and bags filled with</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>clothes. Resident 3's bed was next to Resident 1's bed and there was hardly any room to get to Resident 3's bed due to the clutter around Resident 1's bed. During an interview on [DATE] at 4:05 pm with Resident 3, Resident 1's roommate, Resident 3 stated Resident 3's bed was next to Resident 1's bed and staff (in general) had difficulty providing Resident 3 assistance due to the clutter around Resident 1's bed. During an interview on [DATE] at 4:15 pm with Certified Nursing Assistant (CNA 2), CNA 2 stated it was hard for CNA 2 to help other residents in Resident 1's room because of Resident 1's belongings. During a review of the facility's Policy & Procedure (P&P) titled, Comprehensive Care Plans, revised [DATE], the P&P indicated, Policy: It is the policy of this facility to 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 further indicated, The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.</p>