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	05/22/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for two of two sampled residents (Residents 1 and 48) in accordance with the facility's policy and procedure (P&P) titled Call Lights: Accessibility and Timely Response. These failures had the potential to delay meeting Residents 1 and 48's needs and placed the residents at risk for fall or accident/injury. Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/28/2026 with diagnoses that included muscle wasting and atrophy, other abnormalities of gait (a person's manner of walking and mobility (the ability to move) and schizophrenia (a mental illness characterized by disturbances in thought). During a review of Resident 1's Fall Risk Assessment (FRA- method of assessing a patient's likelihood of falling) dated 3/28/2026, the FRA indicated Resident 1 was assessed as high risk for falls due to Resident 1 having intermittent confusion, was chairbound, had balance problem while standing and walking and required the use of assistive devices. During a review of Resident 1's untitled Care Plan (CP) revised on 3/30/2026, the CP indicated Resident 1 was at risk for falls related to confusion, gait/balance problems and being unaware of safety needs. The CP intervention indicated for the nursing staff to place Resident 1's call light within reach and encourage Resident 1 to use it for assistance as needed. The CP indicated Resident 1 needed prompt response to all requested assistance. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed moderate assistance (helper does less than half the effort) from staff for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 5 needed maximum assistance (helper does more than half the effort) from staff for toileting, shower, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 5/19/2026 at 9:46 am, Resident 1 was awake, lying in bed and unable to find the call light. Resident 1 stated Resident 1 could not find Resident 1's call light. Resident 1's call light was hanging on the left lower part of the bed's side rail. During a concurrent observation and interview on 5/19/2026 at 9:49 am with the Director of Staff and (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
	055104	A. Building B. Wing	05/22/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Development (DSD), the DSD stated Resident 1's call light was on the left side of the bed hanging and Resident 1 was unable to reach the call light. During an interview on 5/19/2026 at 10:20 am with the DSD, the DSD stated Resident 1 was unable to reach and access the call light because it was hanging on the lower left side of the bed. The DSD stated Resident 1 would use the call light if help or assistance was needed. During an interview on 5/21/2026 at 3:38 pm with the facility's Director of Nursing (DON), the DON stated Resident 1's call light needed to be within reach at all times for the residents to be able to ask for help and assistance from staff if needed. b. During a review of Resident 48's AR, the AR indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and a history of falling. During a review of Resident 48's History and Physical (H&P) dated 6/26/2025, the H&P indicated Resident 48 was weak, confused, and was unable to make decisions regarding Resident 48's care. During a review of Resident 48's untitled CP revised on 7/16/2025, the CP indicated Resident 48 was at risk for recurrent falls. The CP interventions indicated for staff to provide a safe environment with the call light within reach and prompt response to all of Resident 48's requests for assistance. During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48 was dependent (helper does all of the effort) to move from lying on the back to sitting on the side of the bed without back support. During an observation on 5/19/2026 at 9:51 am in Resident 48's room, Resident 48 was in bed with the call light on the floor. During a concurrent observation and interview on 5/19/2026 at 9:59 am with Certified Nurse Assistant 1 (CNA 1) in Resident 48's room, Resident 48's call light was on the floor. CNA 1 picked up the call light and placed it on Resident 48's blanket and stated, the call light should not be on the floor and needed to be within reach, so that Resident 48 could call in case anything was needed. During an interview on 5/20/2026 at 11:32 am with Registered Nurse Supervisor 1 (RN 1), RN 1 stated the call light should always be within the resident's reach and accessible to allow the residents to call the nurse if they needed assistance. RN 1 stated, if the call light was not within reach, the resident's safety and needs cannot be met. During an interview on 5/21/2026 at 3:38 pm with the DON, the DON stated the resident's call light needed to be within reach so the residents can request assistance any time. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Call Lights: Accessibility and Timely Response, revised 1/16/2026, the P&P indicated, the call system would be accessible to residents while in their bed or other sleeping accommodations within the resident's room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure policies and procedures (P&P) on Advance Directive (AD, a legal document indicating resident preference on end-of-life treatment decisions) were implemented for two of two sampled residents (Residents 12 and 64) by failing to: a. Ensure Resident 12's Advance Healthcare Directive Acknowledgement Form (ADAF-form that indicated a resident or resident's representative were informed of their rights regarding medical treatments, Advance Directive formulation, and whether an AD was created) was not missing information and completely filled out. b. Ensure Resident 64's copy of Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life) and AD acknowledgement form were in Resident 64's binder and/or uploaded in Resident 64's electronic medical record (EMR). These failures had the potential for the facility staff to provide medical care and services against the will and preferences of Residents 12 and 64. Findings: a. During a review of Resident 12's admission Record (AR), the AR indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by diseases or toxins in the body) and dementia (a progressive state of decline in mental abilities). During a review of Resident 12's History and Physical (H&P) dated 9/18/2025, the H&P indicated Resident 12 had dementia and was unable to make any decisions. During a review of Resident 12's ADAF dated 9/17/2025, the ADAF did not indicate Resident 12's medical record number (MRN) and the resident representative's name/relationship and facility staff names who signed the ADAF. During a concurrent interview and record review on 5/20/2026 at 1:21 pm with the Social Services Director (SSD), Resident 12's ADAF was reviewed. The ADAF did not indicate Resident 12's MRN, Resident 12's representative's name/relationship and the facility staff names who signed the form. The SSD stated Resident 12's ADAF was not accurately done so the ADAF was not complete. The SSD stated based on Resident 12's ADAF, you could not tell who signed as the responsible party (RP-resident representative). The SSD stated the staff who signed the ADAF should have printed their name. The SSD stated, the ADAF was filled out upon admission and needed to be complete because it was a legal document used to ensure the resident's/RP's wishes were followed. During an interview on 5/21/2026 at 3:40 pm with the Director of Nursing (DON), the DON stated Resident 12's ADAF should be completely filled out. The DON stated, the ADAF was a very important piece of information that allowed the facility to follow the resident's/resident representative's wishes for end-of-life care. During a review of the facility's Policy and Procedure (P&P) titled, Documentation in Medical Record, revised 12/19/2022, the P&P indicated, documentation should be accurate, relevant, and complete. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The P&P indicated, each entry would be signed with the name and credentials of the person making the entry. During a review of the facility's P&P titled, Resident's Rights Regarding Treatment and Advance Directives, revised 12/19/2022, the P&P indicated any decision making regarding the resident's choices will be documented in the resident's medical record. b. During a review of Resident 64's admission Record (AR), the AR indicated the facility admitted Resident 64 on 4/11/2026 with diagnoses including osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and right knee joint replacement surgery (removes damaged bone and cartilage in a joint and replaces with durable artificial implants). During a review of Resident 64's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated Resident 64 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 64 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 64 required partial/moderate assistance (helper did less than half the effort) with toileting, and lower body dressing. The MDS indicated Resident 64 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with shower. During a concurrent interview and record review on 5/19/2026 at 2:15 pm with the Medical Records staff (MR), Resident 64's binder (binder with residents' physical copy of POLST and AD acknowledgement form) and Resident 64's EMR were reviewed. The MR stated there was no copy of POLST and AD acknowledgement form in the binder and there was no copy uploaded in Resident 64's EMR. The MR stated Resident 64 was admitted to the facility on [DATE] and had been in the facility for five (5) weeks. During an interview on 5/19/2026 at 2:18 pm with Registered Nurse Supervisor 2 (RN 2), RN 2 stated POLST and AD acknowledgement form should be filled and completed upon admission to ensure the resident or responsible party were informed of the resident's rights to formulate an AD and received information to determine resident's preferences and wishes regarding care in the facility and during emergency. During an interview on 5/21/2026 at 3:34 pm with the Director of Nursing (DON), the DON stated a copy of POLST and AD acknowledgement form should be in the binder, a copy uploaded in the resident's EMR and accessible to the staff to address and identify the resident's end-of-life wishes and preferences. During a review of the facility's P&P titled, Residents' Rights Regarding Treatment and Advance Directives, implemented on 12/19/2022, the P&P indicated, On admission, the facility will determine if the resident has executed and advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent unnecessary use of psychotropic medications (any medication capable of affecting the mind, emotions, and behavior) according to the facility's policy and procedure and the resident's care plan for two of five sampled residents (Residents 1 and 73) by failing to: a. Ensure the adverse side effects (unwanted or harmful effect) was monitored for the use of Divalproex (mood stabilizer or treatment of seizures), Clozapine (antianxiety medication to treat anxiety [group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear]), Olanzapine (antipsychotic medication to treat mental disorder) oral tablet 5 milligrams (mg, unit of measurement) and Trazodone (antidepressant - medication to treat depression [mood disorder that causes a persistent feeling of sadness and loss of interest]) for Resident 1. b. Ensure Resident 73's Duloxetine antidepressant use included specific target behavior for use. These deficient practices had the potential to result in significant adverse (harmful) consequences for Residents 1 and 73. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/28/2026 with diagnoses including muscle wasting and atrophy, schizophrenia (a mental illness that is characterized by disturbances in thought) and unspecified psychosis (loss of contact with reality). During a review of Resident 1's untitled Care Plan (CP) initiated on 3/30/2026, the CP indicated Resident 1 was on sedative (medication that slows down brain activity to produce calmness, relieve anxiety, or sleep)/hypnotic (prescription sleeping pills) therapy of Trazodone related to insomnia (trouble falling asleep or staying asleep). The CP intervention indicated for nursing staff to administer psychotropic medications as ordered by the physician and to monitor for any side effects. During a review of Resident 1's Order Summary Report (OSR) dated 3/30/2026, the OSR indicated for licensed staff to administer Divalproex Sodium Oral Tablet Delayed Release (Divalproex Sodium) 250 milligrams (mg- unit of measurement) by mouth two times a day for mood stabilizer manifested by mood swings. During a review of Resident 1's OSR dated 4/2/2026, the OSR indicated for licensed staff to administer Clozapine oral tablet 50 mg one tablet by mouth one time a day for schizophrenia manifested by auditory hallucinations (when a person hears sounds that are not present in the environment). During a review of Resident 1's untitled CP initiated on 4/2/2026, the CP indicated Resident 1 was on psychotropic medication Clozapine related to schizophrenia manifested by auditory hallucinations. The CP indicated Resident 1 was on Olanzapine for psychosis and Divalproex for mood stabilizer. The CP intervention indicated for nursing staff to administer psychotropic medications as ordered by the physician and to monitor for side effects. During a review of Resident 1's OSR dated 4/7/2026, the OSR indicated for licensed staff to administer Olanzapine oral tablet 10 mg 1 tablet by mouth one time a day for psychosis manifested by increased aggression. During a review of Resident 1's OSR dated 4/7/2026, the OSR indicated for licensed staff to administer Trazodone HCl Oral Tablet 100 mg one tablet by mouth at bedtime for depression manifested by inability to sleep. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/7/2026, the MDS indicated Resident 1 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 needed moderate assistance (helper does less than half the effort) from staff for eating, oral hygiene, and upper body dressing. The MDS indicated Resident 5 needed maximum assistance (helper does more than half the effort) from staff for toileting, shower, lower body dressing and putting on/taking off footwear. During a concurrent interview on 5/20/2026 at 12:50 pm with the facility's Director of Nursing (DON) and record review of Resident 1's medical records (PointClickCare - PCC, a cloud-based software) was reviewed. The DON stated there was no monitoring done for Resident 1's adverse side effects of Divalproex, Clozapine, Olanzapine and Trazodone used. The DON (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated psychotropic medication side effects needed to be monitored every shift by licensed nurses to prevent adverse reactions of medications. b. During a review of Resident 73's AR, the AR indicated the facility admitted Resident 73 on 2/6/2026 with diagnoses including respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) and depression. During a review of Resident 73's untitled CP initiated on 2/6/2026, the CP indicated Resident 73 was on antidepressant medication Duloxetine related to depression. The CP intervention indicated for nursing staff to monitor/document/report as needed any adverse reactions to antidepressant therapy: dry mouth, constipation, blurred vision, disorientation, confusion, difficulty urinating, hypertension (high blood pressure), dark urine, yellow skin, nausea and vomiting, lethargy (an abnormal state of extreme tiredness and severe lack of energy), drooling, dizziness, diarrhea, anxiety (emotion characterized by an unpleasant state of inner turmoil), nervousness, insomnia, somnolence (excessive drowsiness or a strong desire to sleep during the day), weight gain, anorexia (an eating disorder that causes a severe and strong fear of gaining weight), or increased appetite; many of these effects can increase the risk for falls. During a review of Resident 73's untitled CP initiated on 2/9/2026, the CP indicated Resident 73 was on Duloxetine for depression manifested by sad facial expressions. The CP intervention indicated for nursing staff to administer medications as ordered and to monitor/document for side effects and effectiveness. During a review of Resident 73's OSR dated 4/8/2026, the OSR indicated for licensed staff to administer Duloxetine Hydrochloride Oral Capsule Delayed Release Sprinkle 30 mg by mouth one time a day for depression manifested by sad facial expressions. During a review of Resident 73's MDS dated [DATE], the MDS indicated Resident 73 had moderately impaired cognition for daily decision making. The MDS indicated Resident 73 needed maximum assistance (helper does more than half the effort) from staff for toileting and shower. The MDS indicated Resident 5 needed moderate assistance from staff for lower body dressing and set up assistance (helper sets up or cleans up) for eating, oral hygiene, upper body dressing and personal hygiene. During a concurrent interview on 5/20/2026 at 12:31 pm with the facility's DON and record review of Resident 73's PCC, the DON stated Resident 73 was on Duloxetine for depression manifested by sad facial expressions. The DON stated sad facial expression was not a specific target behavior. The DON stated Resident 73 was able to express needs and feelings. During a review of the facility's Policy and Procedure (P&P) titled, Use of Psychotropic Medication, revised 1/16/2026, the P&P indicated, Psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The effects of psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive care plan. The resident's response to the medication(s), including progress towards the goal and presence/absence of adverse consequences, shall be documented in the resident's medical record.

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	05/22/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a specific and individualized resident-centered care plan to meet the residents' needs for two of two sampled residents (Residents 14 and 26) by failing to:a. Develop a care plan for Resident 14 who was on enhanced barrier precaution (EBP, infection control measures to prevent the spread of multidrug resistant organisms [MDRO]). b. Develop a care plan for Resident 26 for the use of antibiotic therapy (medications used to treat and prevent infections caused by bacteria). These failures had the potential for Residents 14 and 26 not to receive necessary care, treatment, and services to address the residents' specific needs. Findings: a. During a review of Resident 14's admission Record (AR), the AR indicated the facility admitted Resident 14 on 3/1/2026 with diagnoses including End Stage Renal Disease (ESRD- a condition in which the kidneys cease functioning on a permanent basis) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/5/2026, the MDS indicated Resident 14 was receiving dialysis. During a review of 14's Order Summary Report (OSR), the OSR indicated Resident 14 had an active order for Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities and are indicated for residents with infections, wounds, and indwelling medical devices) related to a right arm arteriovenous shunt (direct connection between an artery and a vein created for medical treatment), ordered on 4/24/2026. During a concurrent observation and interview on 5/19/2026 at 11:20 am with Resident 14 in the patio area, Resident 14 had a right upper arm dressing. Resident 14 stated, Resident 14 received hemodialysis treatments every Tuesdays, Thursdays, and Saturdays. During a concurrent interview and record review on 5/20/2026 at 2:47 pm with Licensed Vocational Nurse 1 (LVN 1), Resident 14's current Care Plans (CP) was reviewed and did not indicate a care plan addressing Resident 14's EBP. LVN 1 stated Resident 14 had a physician's order for EBP and Resident 14 should have a CP to prevent an infection of the AV shunt, harmful to Resident 14. During an interview on 5/21/2026 at 3:36 pm with the Director of Nursing (DON), the DON stated CPs should be resident-specific and a CP should be initiated and implemented for EBP. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, last (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised 1/16/2026, the P&P indicated, it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident. The P&P indicated, the comprehensive CP would describe at a minimum the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. During a review of Resident 26's AR, the AR indicated the facility admitted Resident 26 on 4/13/2026 with diagnoses including pneumonia (an infection/inflammation in the lungs), infection of left lower extremity amputation (surgical removal of the portion of the leg) stump, and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool) dated 5/1/2026, the MDS indicated Resident 26 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 26 required partial/moderate assistance (helper did less than half the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 26 was dependent (helper did all the effort, resident did none) with toileting and showering/bathing self. During a review of Resident 26's Order Summary Report (OSR) dated 5/13/2026, the OSR indicated Resident 26 had an order for Bactrim DS (a combination prescription antibiotic) tablet 800-160 milligrams (mg-unit of measurement), two times a day for left below the knee (BKA, surgical removal of the portion of the leg below the knee) infection. During a concurrent interview and record review on 5/21/2026 at 12:25 pm with the Director of Staff Development (DSD), Resident 26's OSR dated 5/13/2026 and CPs were reviewed. The DSD stated Resident 26 had a left BKA infection and was on antibiotic therapy up to 5/25/2026. The DSD stated there was no care plan developed and initiated for Resident 2 for the use of antibiotics. The DSD stated the resident's care plan should be developed for any concerns of the resident based on diagnosis, assessment, medication, and treatment. The DSD stated Resident 26 should have a care plan to address the use of antibiotics to monitor Resident 26's response to the treatment or intervention and presence of any side effects (any secondary unintended effect of a medical treatment or medication) and/or adverse reactions (unintended, harmful, or unpleasant effect caused by medication, treatment or procedure). During an interview on 5/21/2026 at 3:34 pm with the Director of Nursing (DON), the DON stated a care plan needed to have interventions and goals specific to the residents to guide staff on how to provide necessary care and to monitor and determine if interventions developed in the care plan were effective. During a review of the facility's Policy and Procedures (P&P) titled, Comprehensive Care Plans, reviewed on 1/16/2026, the P&P indicated, The comprehensive care plan will describe, at a minimum, the following: The services are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to revise the resident's care plan for one of one sampled resident (Resident 73) to reflect Pneumocystis Jirovecii Pneumonia (PJP, life-threatening fungal lung infection) prophylaxis in accordance with the facility's Policy and Procedure (P&P) on comprehensive care plan. This failure had the potential to not provide Resident 73 with necessary care and services and compromise Resident 73's safety. Findings: During a review of Resident 73's admission Record (AR), the AR indicated the facility admitted Resident 73 on 2/6/2026 with diagnoses including respiratory failure (a condition when the lungs cannot get enough oxygen into the blood) and depression (persistent feeling of sadness and loss of interest). During a review of Resident 73's untitled Care Plan (CP) initiated on 2/6/2026, the CP indicated Resident 73 was on antibiotic therapy of Bactrim Double Strength (antibiotic used to kill bacteria causing infections) Oral tablet 800 to 160 milligram (mg, unit of measurement) related to encephalitis (swelling or inflammation of the brain). The CP intervention indicated for licensed nursing staff to administer antibiotic medication as ordered by the physician. During a review of Resident 73's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/7/2026, the MDS indicated Resident 73 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 73 needed maximum assistance (helper does more than half the effort) from staff for toileting and showering. The MDS indicated Resident 5 needed moderate assistance (helper does less than half the effort) from staff for lower body dressing and set up assistance (helper sets up or cleans up) from staff for eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 73's Order Summary Report (OSR) dated 5/14/2026, the OSR indicated for licensed staff to administer Bactrim DS Oral Tablet 800 - 160 mg, 1 tablet by mouth in the morning every Monday, Wednesday, Friday for Pneumocystis Jirovecii Pneumonia. During an observation on 5/19/2026 at 12:21 am inside Resident 73's room, Resident 73 was awake, lying in bed. During a concurrent interview and record review on 5/20/2026 at 11:25 pm with the Quality Assurance Nurse (QAN) of Resident 73's medical records (PointClickCare - PCC, a cloud-based software) was reviewed. The QAN stated Resident 73's CP for antibiotic therapy was not revised when the licensed nurse received the order from the physician on 5/14/2026 for PJP prophylaxis. The QAN stated the licensed nurse should revise the CP when there was a change in the resident's condition that needed nursing interventions to be updated. The QAN stated Resident 73's CP needed to be updated to provide necessary and quality care, according to the resident's needs while receiving antibiotics. During an interview on 5/21/2026 at 3:36 pm with the Director of Nursing (DON), the DON stated the licensed nurse did not update Resident 73's CP for antibiotic use to reflect what Resident 73 was treated for. The DON stated Resident 73's CP should have been revised to guide the staff on how to provide care and treatment to Resident 73. During a review of the facility's P&P titled, Comprehensive Care Plans, revised 1/16/2026, the P&P indicated, The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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	055104	A. Building B. Wing	05/22/2026

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to ensure non-English speaking (refers to an individual who cannot speak or understand or have difficulty speaking or understanding the English language) residents were provided with a communication board/device in a language that the resident understood for one of one sampled resident (Resident 2). This failure had the potential to affect Resident 2's communication with staff resulting in delay in the provision of care, treatment and service to Resident 2.Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 2/6/2026 with diagnoses including dementia (a progressive state of decline in mental abilities), anxiety (a feeling of fear, dread, or unease) and history of falling. During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 5/7/2026, the MDS indicated Resident 2's preferred language was Cantonese. The MDS indicated Resident 2 had severely impaired cognition (ability to understand and process information) for daily decision making. The MDS indicated Resident 2 required partial/moderate assistance (helper did less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 2 was dependent (helper did all the effort) with toileting, shower and lower body dressing. During a concurrent observation inside Resident 2's room and interview on 5/19/2026 at 9:40 am with Restorative Nurse Assistant 1(RNA 1), Resident 2 was speaking in a language other than English. RNA 1 stated Resident 2's language was Cantonese. RNA 1 stated Resident 2 did not speak or understand English. RNA 1 stated Resident 2 did not have a communication board in the room. RNA 1 stated that residents whose primary language (language an individual uses most frequently and proficiently) was not English should have a communication board with pictures and descriptions of their spoken language in the room. RNA 1 stated the communication board would assist the residents to communicate basic needs and help staff better understand and meet the residents' needs. During an interview on 5/21/2026 at 3:34 pm with the Director of Nursing (DON), the DON stated all non-verbal, but alert and oriented residents and non-English speaking residents should have a communication board in the room to express their needs and for staff to be able to address the resident's needs appropriately. During a review of the facility's Policy and Procedures (P&P) titled, Effective Communication, revised 1/16/2026, the P&P indicated, Staff will communicate with the resident, using techniques identified in their plan of care, and in accordance with his/her established routine for communication, as possible. Adaptive techniques include but are not limited to: Using communication boards or writing materials (i.e. write legibly, in plain terms).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure the Foley Catheter (FC, a thin, flexible, rubber or plastic tube used to drain urine from the bladder) was secured on the resident's thigh in accordance with the facility's Policy and Procedure (P&P) Indwelling Catheter Use and Removal, for one of two sampled residents (Resident 27). This failure had the potential to result in catheter-related complications for Resident 27.Findings: During a review of Resident 27's admission Record (AR), the AR indicated the facility admitted Resident 27 on 5/4/2026 with diagnoses including obstructive and reflux uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional) and benign prostatic hyperplasia (BPH, a noncancerous enlargement of the prostate gland). During a review of Resident 27's untitled Care Plan (CP) initiated on 5/5/2026, the CP indicated Resident 27 had an indwelling catheter related to obstructive and reflux uropathy due to BPH. The CP intervention indicated for nursing staff to monitor/document for pain/discomfort due to the use of a catheter. During a review of Resident 27's Minimum Data Set (MDS, a resident assessment tool) dated 5/8/2026, the MDS indicated Resident 27 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 27 was dependent (helper does all of the effort) from staff with toileting, shower, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 27 needed maximum (helper does more than half the effort) assistance from staff with oral hygiene, upper body dressing and personal hygiene. During a review of Resident 27's Order Summary Report (OSR) dated 5/5/2026, the OSR indicated for licensed staff to insert indwelling (foley) catheter, French (a type of catheter) 16 (size of the catheter), change for blockage, leaking, pulled out and excessive sedimentation (visible particles in the urine); change catheter drainage bag as needed and with every change of FC as needed for obstructive uropathy. During an observation on 5/19/2026 at 9:39 am inside Resident 27's room, Resident 27 was awake, lying in bed with FC hanging on the right side of the bed. During a concurrent observation inside Resident 27's room and interview on 5/19/2026 at 9:42 am with the Director of Staff and Development (DSD), the DSD stated Resident 27's FC tubing was not secured with a securement device. The DSD stated the FC tubing should be secured properly on Resident 27's right thigh to prevent the tubing from being pulled out and to prevent injury during Resident 27's movement or activities of daily living (ADL). During an interview on 5/21/2026 at 3:30 pm with the facility's Director of Nursing (DON), the DON stated, Resident 27's FC tubing needed to be secured with a securement device to ensure the FC would not be pulled out during care and prevent injury to the resident. During a review of the facility's Policy and Procedure (P&P) titled Indwelling Catheter Use and Removal, revised 1/16/2026, the P&P indicated, Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter and securement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure residents on oxygen therapy (treatment that provides supplemental, or extra oxygen) had an oxygen in use warning sign posted outside the room for one of one sampled resident (Resident 26). This failure placed Resident 26, facility staff and visitors at risk of the dangers of accidental fire and injury. Findings: During a review of Resident 26's admission Record (AR), the AR indicated the facility admitted Resident 26 on 4/13/2026 with diagnoses including pneumonia (an infection/inflammation in the lungs), dementia (a progressive state of decline in mental abilities), and heart failure (HF, a heart disorder which causes the heart to not pump blood efficiently). During a review of Resident 26's untitled Care Plan (CP) initiated on 4/24/2026, the CP indicated Resident 26 had altered respiratory status/difficulty breathing. The CP goals included Resident 26 would not have complications related to shortness of breath and signs and symptoms of poor oxygen absorption. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool) dated 5/1/2026, the MDS indicated Resident 26 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 26 required partial/moderate assistance (helper did less than half the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 26 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with toileting and shower. During a review of Resident 26's Order Summary Report dated 5/13/2026, the OSR indicated Resident 26 had an order for oxygen via (by way of/through) nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 2 liters per minute (l/min) as needed for shortness of breath/wheezing (abnormal breath sound). During a concurrent observation inside Resident 26's room and interview on 5/20/2026 at 1:16 pm with the Infection Prevention Nurse (IPN), Resident 26 was in bed with ongoing oxygen at 2 l/min via NC. The IPN stated there was no oxygen in use warning sign posted outside Resident 26's room. The IPN stated all residents with ongoing oxygen therapy should have an oxygen in use warning sign posted outside the residents' room indicating oxygen was in use and smoking was prohibited and to remind visitors and other residents not to smoke inside the room for the safety of the resident and staff in the facility. During an interview on 5/21/2026 at 3:34 pm with the Director of Nursing (DON), the DON stated residents on oxygen therapy should have an oxygen in use warning sign posted outside the residents' room to alert visitors and residents not to smoke inside the residents' room to avoid fire and for residents' safety. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Concentrator, revised 1/16/2026, the P&P indicated, The purpose of the policy is to establish responsibilities for the care and use of oxygen concentrators. Place an oxygen warning sign on the resident's door. Remove smoking materials, electric razors or other spark-generating electrical appliances from the room and explain the reasons to the resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to implement its Policy and Procedure (P&P) on the use of bed rails/siderails (adjustable metal or rigid plastic bars attached to the bed) for one of one sampled resident (Resident 64). This failure placed Resident 64 at risk for entrapment and injury from the use of bed rails.Findings: During a review of Resident 64's admission Record (AR), the AR indicated the facility admitted Resident 64 on 4/11/2026 with diagnoses including osteoarthritis (a progressive disorder of the joints caused by a gradual loss of cartilage) and right knee joint replacement surgery (removal of damaged bone and cartilage in a joint and replaced with durable artificial implants). During a review of Resident 64's Bed Rails Assessment (BRA) dated 4/11/2026, the BRA indicated Resident 64 did not need the use of bed rails. During a review of Resident 64's Minimum Data Set (MDS, a resident assessment tool) dated 4/15/2026, the MDS indicated Resident 64 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 64 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 64 required partial/moderate assistance (helper did less than half the effort) with toileting, and lower body dressing. The MDS indicated Resident 64 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with shower. During a review of Resident 64's Order Summary Report (OSR) with active orders as of 5/19/2026, the OSR did not indicate an order for the use of bilateral one-half (1/2) bed rails) for Resident 64. During a concurrent observation inside Resident 64's room and interview on 5/19/2026 at 9:58 am with Certified Nurse Assistant 2 (CNA 2), Resident 64 was sitting on the edge of the bed with bed rails/siderails up on both sides of the bed. CNA 2 stated Resident 64 was able to sit, stand and walk with supervision. Resident 64 stated Resident 64 did not need the siderails and did not request the installation of siderails. During a concurrent interview and record review on 5/19/2026 at 2:15 pm with the Medical Records staff (MR), Resident 64's electronic medical record (EMR), OSR with active orders as of May 2026 and BRA dated 4/11/2026 were reviewed. The MR stated the OSR did not indicate Resident 64 had an order for the use of bilateral 1/2 bed rails. The MR stated the BRA did not indicate Resident 64 needed the use of side rails during the assessment. The MR stated Resident 64 did not have a consent for the use of bilateral 1/2 siderails in the EMR. During an interview on 5/19/2026 at 2:20 pm with Registered Nurse Supervisor 2 (RN 2), RN 2 stated residents with bed siderails should have a physician's order and consent obtained from the resident or responsible party before the installation of bed rails/siderails for the safety of the resident and to prevent injury. During an interview on 5/21/2026 at 3:34 pm with the Director of Nursing (DON), the DON stated a physician's order and consent should be obtained before the installation of bed rails/siderails because bed rails/siderails were considered as restraints and this would prevent potential entrapment and injury to the residents. During a review of the facility's P&P titled, Proper Use of Bed Rails, revised 1/16/2026, the P&P indicated, Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail.

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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. Based on observation, interview, and record review, the facility failed to keep one of two laundry dryers in a safe, operating, and sanitary condition for residents. This failure had the potential to result in spread of infection and posed as potential fire hazard. Findings: During a concurrent observation and interview on 5/21/2026 at 12:40 pm with Housekeeping 1 (HKP 1) in the facility's laundry room, there were two dryers (container to put wet laundry for drying) in the facility's laundry room. One dryer had multiple random thick patches of light brown material on the dryer lint trap. HKP 1 stated HKP 1 did not monitor, sign and complete the Dryer Lint Clean Out Schedule Form because it was unreadable. HKP 1 stated the dryer lint trap needed to be cleaned every 2 hours to avoid potential fire. During a concurrent interview on 5/21/2026 at 12:42 pm with Housekeeping Supervisor (HKP Sup) and record review of the Dryer Lint Clean Out Schedule Form, the HKP Sup stated the dryer lint trap was thick and lint has accumulated. The HKP Sup stated the dryer lint trap should have been cleaned every 2 hours to avoid fire and prevent infection. The HKP Sup stated the Dryer Lint Clean Out Schedule Form was filled out by mistake by the Housekeeping Staff (unidentified) this morning. The HKP Sup stated the unidentified HK staff filled out the form until 8pm on 5/21/2026. The HKP Sup stated the Dryer Lint Clean Out Schedule Form should be filled out timely every after cleaning and not in advance. During a review of the undated facility's Policy and Procedure (P&P) titled, Lint Trap Cleaning Policy, the P&P indicated, All laundry staff required to clean and inspect dryer lint traps every 2 hours during operational hours and additionally whenever excessive lint buildup is observed. Proper lint trap maintenance is mandatory for fire prevention, infection control and equipment safety. Laundry staff shall document lint trap cleanings on the designated Laundry Lint Trap Cleaning Log including date, time cleaned, and employee initials/signature.