

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2024
NAME OF PROVIDER OR SUPPLIER Sunset Park Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 2250 29th Street Santa Monica, CA 90405	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>45455</p> <p>Based on interview and record review the facility failed to protect one of four sampled residents (Resident 1) and from verbal abuse (the use of oral, written, or gestured communication, or sounds, to residents; including harassing, mocking, yelling, cussing, or threatening) by failing to ensure Licensed Vocational Nurse 2 (LVN2) did not engage in a verbal altercation with Resident 1 and cuss at Resident 1.</p> <p>As a result, Resident 1 was exposed to verbal abuse from LVN2, placing the Resident 1 at risk for psychosocial harm, mental anguish (suffering) and emotional distress.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated the facility admitted Resident 1 on 5/16/2024, with diagnoses that included encephalopathy (a disorder of the brain caused by disease, injury, drugs, or chemicals), psychosis (a mental disorder in which a person loses the ability to recognize reality or relate to others), depression and anxiety disorder.</p> <p>A review of Resident 1's Minimum Data Set (MDS- standardized data collection tool used to assess cognitive brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) and functional status, and care needs) dated 5/16/2024, indicated Resident 1 had moderate cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment.</p> <p>A review of Resident 1's situation background assessment and recommendation (SBAR: a form that is a documentation of a complete assessment in response to a change in condition) form dated 5/22/2024 at 6:10 pm, indicated Resident 1 had a verbal altercation with a staff member (LVN2). The SBAR form indicated Resident 1 was placed on 72-hour monitoring.</p> <p>A review of a facility document titled Corrective Action Memo dated 5/29/2024, indicated On 5/22/2024 the employee (LVN2) stated that on 5/16/2024 she cursed at a resident (Resident 1) in violation of the facility's abuse preventions policy and procedure, facility code of conduct, and nursing code of conduct.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility document titled Termination of Employment/Exit Interview dated 5/29/2024, indicated LVN2's employment with the facility was terminated effective 5/29/2024, with a last date of work of 5/22/2024. The document indicated the reason for termination was Employee violated abuse policy and procedures.</p> <p>During an interview on 6/11/2024 at 10:25am, Resident 1 denied experiencing verbal abuse from the facility staff stating, I don't remember.</p> <p>During an interview on 6/11/2024 at 12:10 pm, Administrator (ADM) stated on 5/22/2024 during a 1:1 (one to one) education on ways de-escalating and re-directing a resident in crisis prompted by LVN2s history of unnecessary emergency calls to 911. ADM stated LVN 2 made a huge stink about Resident 1 psychological distress and admitted during the meeting that she (LVN2) told Resident1 fuck you (FU). ADM further stated that's how to handle stuff and it works.</p> <p>During an interview on 6/13/2024 at 10:45 am LVN2 stated on 5/16/2024 while getting ready to pass medications, LVN2 observed Resident 1 grabbing the receptionist's computer keyboard and a condensed aerosol spray that were on the receptionist desk then proceeded to bang the computer keyboard on the reception desk. Resident 1 seemed enraged without provocation. Resident 1 swung the computer keyboard and attempted to spray any staff who tried to calm him down or approach him. LVN2 stated she called 911 as Resident 1's aggression escalated because she was concerned about the safety of the other Residents and staff in the facility. LVN2 denied verbally abusing Resident 1.</p> <p>A review of LVN2's employee file indicated LVN2 a current license, had no previous disciplinary actions. A facility background check dated 6/11/2024 indicated there were no concerns on LVN2 license record and, facility records indicated LVN2 was provided with initial abuse and code of conduct training on 2/14/2023.</p> <p>A review of the facility's policy and procedures (P&P) titled Abuse Prevention dated, revised 12/2018, indicated, facility does not condone any form of Resident abuse . including verbal abuse . Verbal abuse is defined as any use of oral, written, gestured communication or sounds that willfully includes disparaging and derogatory terms directed to residents within their hearing distance regardless of age, ability to comprehend or disability.</p> <p>A review of the facility P&P titled Code and Behavior dated, revised 5/2019, indicated, conduct that interferes with the care of residents any act that is offensive to a resident . will not be condoned and may be grounds for disciplinary action. Examples conduct, and behavior considered inappropriate and therefor prohibited by this policy include but are not limited to: .using profanity, abusive or suggestive language or gestures.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>45455</p> <p>Based on observation, interview, and record review, the facility staff failed to inform one of four sampled residents (Resident 1) and Resident 1's representative/family/responsible party that Resident 1 would be discharged from Skilled Nursing Facility 1 (SNF1) to SNF2 before 5/16/2024.</p> <p>This deficient practice resulted in SNF1 transferring Resident 1 to SNF2 on 5/16/2024. Resident 1 became aggressive towards staff and difficult to manage at SNF2.</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated the facility admitted Resident 1 on 5/16/2024, with diagnoses that included encephalopathy (a disorder of the brain caused by disease, injury, drugs, or chemicals), psychosis (a mental disorder in which a person loses the ability to recognize reality or relate to others), depression and anxiety disorder.</p> <p>A review of Resident 1's Minimum Data Set (MDS- standardized data collection tool used to assess cognitive brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) and functional status, and care needs) dated 5/16/2024, indicated the resident had moderate cognitive (ability to think, read, learn, remember, reason, express thoughts, and make decisions) impairment.</p> <p>During an interview on 6/11/2024 at 12:01 pm social services director (SSD) stated Resident 1 was discharged from Skilled Nursing facility 1 (SNF1-a locked facility) to SNF2 (an open facility) on 5/22/2024 in preparation for Resident 1 to transition into the general community. SSD stated SSD received a call from a staff at SNF2 on the way home from work with SNF2 staff stating that SNF2 was having difficulty re-directing Resident 1 who was acting volatile and trying to elope from the facility. SSD stated Resident 1 had mood swings and difficulty trusting new people. SSD stated Resident 1 usually takes time to warm up to staff when in a new environment.</p> <p>During a telephone interview on 6/13/2024 at 10:45 am Licensed Vocational Nurse 2 (LVN2) stated that on 5/16/2024 while getting ready to pass medications to other residents, LVN2 observed Resident 1 grabbing the receptionist's computer keyboard and a condensed aerosol spray that were on the receptionist desk then proceeded to bang the computer keyboard on the reception desk. Resident 1 seemed enraged without provocation. Resident 1 swung the computer keyboard and attempted to spray any staff who tried to calm or approach Resident 1. LVN2 stated LVN2 called 911 as Resident 1's aggression escalated and was concerned about the safety of the other residents and staff in the facility. LVN2 stated LVN2 called the administrator (ADM) responsible for both SNF1 and SNF2</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/18/2024 at 9:49 am speech therapist (ST) stated ST observed Resident 1 being aggressive and tried with the help of other staff to de-escalate and re-direct him. ST stated Resident 1 threw a box of gloves, masks, hand sanitizer bottle and keyboard that were at the Receptionist desk towards staff. ST stated Resident 1 went to the Rehab room and started throwing things and was touching patients and at the same time hitting employees. ST stated ST observed Resident 1 going to other Residents rooms touching their heads and invading their personal space, refusing re-direction, being verbally aggressive, rude, and throwing everything he could to grab at facility staff. ST stated SNF2 nurses and staff tried to call for help from the police, but the police never showed up.</p> <p>During a telephone interview on 6/18/2024 at 11:50 am, CNA3 stated CNA3 arrived for to work at SNF2 and was surprised to see Resident 1 at SNF2 instead of SNF1. CNA3 stated CNA3 kept a watchful eye on Resident 1 because CAN 3 remembered being told while working at SNF1 that Resident 1 had a history of being aggressive. CNA3 stated CNA3 heard a loud banging noise in the hallway and observed Resident 1 at SNF2 reception area banging the Receptionists keyboard on the desk and spraying an aerosol spray at any staff who tried to approach Resident 1. CNA3 stated Resident 1 was aggressive, difficult to re-direct and was getting out of hand. CNA3 stated LVN2, decided to call 911 because Resident 1 was trying to destroy property and was a danger to himself, other Residents and Staff.</p> <p>A review of Resident 1's Admission Note dated 6/18/2024, indicated Resident 1 was admitted to SNF2 on 5/16/2024 at 1:45 pm and discharged back to SNF1 on 5/16/2024 at 9:13 pm.</p> <p>A review of the facility's policy and procedures title, Admissions Policies dated, revised 12/2006 indicated, the objectives of our admission policies are to . admit residents who can be adequately cared for by the facility.</p>		