

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 04/04/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on interview and record review, the facility failed to implement their policy regarding reporting of a resident-to-resident altercation and to submit a conclusion report of investigation within five days or in accordance with state or federal law for two of five sampled residents (Resident 1 and Resident 2).</p> <p>This resulted in a delay of an onsite inspection by the Department of Public Health to ensure the residents' allegation of abuse was investigated which can also lead to a delay in prevention of further abuse for Resident 1 and Resident 2.</p> <p>Cross Reference F610.</p> <p>Findings:</p> <p>A. During a review of the Resident 1 ' s Admission Record, it indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought) and peripheral vascular disease (PVD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>During a review of the Minimum Data Set (MDS - resident assessment tool) dated 3/12/2025, indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were mildly impaired. The MDS indicated Resident 1 was independent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 5/17/2024, the H&P indicated, Resident 1 has the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Progress Notes dated:</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>i. On 3/27/2025, the Progress Notes written by Registered Nurse 1 (RN 1) indicated, Staff approached Registered Nurse 1 (RN 1) and notify that at around 12 p.m., they witnessed Resident 1 being physically aggressive to another resident (Resident 2). The incident occurred when Resident 2 was attempting to open the patio door to go inside, Resident 1 was behind him was doing the same thing too, Resident 2 ' s action startled Resident 1 and he (Resident 1) began screaming and yelling inappropriately to Resident 2. Resident 1 started raising his fist and became physically aggressive to Resident 2 who was trying to defend himself . Resident 1 continued to scream and yell and stated that there will be a round two later.</p> <p>ii. On 4/3/2025, the Progress Notes, written by Licensed Vocational Nurse 1 (LVN 1) indicated, Resident (1) was seen arguing with another resident outside the patio. A Certified Nursing Assistant witnessed the altercation and has provided a statement . Resident 1 stated that other resident got on his personal space, and both argued about space.</p> <p>During an interview with LVN 1 on 4/4/2025 at 11:05 a.m., LVN 1 stated, on 4/3/2025, there was a verbal altercation between Resident 1 and Resident 2. LVN 1 stated, she reported the incident to the Administrator and Director of Nursing (DON).</p> <p>B. During a review of the Resident 2 ' s Admission Record, it indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including hemiplegia and hemiparesis (loss of the ability to move in one side of the body) following cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue) affecting right dominant side, aphasia (a disorder that makes it difficult to speak) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of the MDS dated [DATE], indicated Resident 2 ' s cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 required moderate assistance to supervision from staff for ADLs.</p> <p>During a review of Resident 1 ' s H&P dated 3/18/2025, the H&P indicated, Resident 2 was unable to communicate/make decisions for self.</p> <p>During a review of Resident 1 ' s Progress Notes dated:</p> <p>i. On 3/27/2025, the Progress Notes written by LVN 1 indicated, Resident (2) is alert and oriented, difficulty with speech but is able to answer questions with a yes and no. Resident 2 was involved in an untoward incident with another resident. Frequent round checks were done for this resident, no noted and reported emotional or psychological distress.</p> <p>ii. On 4/3/2025, the Progress Notes written by Licensed Vocational Nurse 2 (LVN 2) indicated, Resident (2) was seen arguing with another resident outside the patio. A Certified Nursing Assistant witnessed the altercation and has provided a statement . Resident 2 stated that other resident got in his personal space and both argued about space.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review with Director of Nursing (DON) on 4/4/2025 at 12 p.m., DON stated, Resident 1 and Resident 2 had altercation on 3/27/2025 and again on 4/3/2025, where they separated both residents from each other. DON stated, they investigated the incidents but were unable to provide any documentation of the investigation and the outcome. DON further stated, this was not reported to the State Agency (SA).</p> <p>During an interview with Administrator (ADM) on 4/4/2025 at 12:26 p.m., ADM stated, she was not made aware of the incident between Resident 1 and Resident 2. ADM reviewed Resident 1 and Resident 2 ' s medical record and stated, she will now be reporting the incident to the SA.</p> <p>A review of the facility's policy and procedures (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised on 4/2024, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported . The Administrator or individual making the allegation immediately reports his or her suspicion to the following persons or agencies:</p> <ul style="list-style-type: none"> A. the state licensing/certification agency responsible for surveying/licensing the facility b. the local/state ombudsman c. The resident ' s representative d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident ' s attending physician; and g. The facility medical director. <p>Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury . Within five business days of the incident, the administrator will provide a follow-up investigation report. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegation was verified.</p> <p>During a review of the facility ' s P&P titled, Resident-to-Resident Altercations, revised on 4/2024, the P&P indicated, All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported to the nursing supervisor, the director of nursing services and to the administrator . If two residents are involved in an altercation, staff will: report incidents, findings, and corrective measures to appropriate agencies as outlined in our facility's abuse reporting policy.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43454</p> <p>Based on record review and interview, the facility failed to implement its abuse policy and procedure by failing to investigate a resident-to-resident altercation between two of five sampled residents (Resident 1 and Resident 2).</p> <p>This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from abuse.</p> <p>Cross Reference F609.</p> <p>Findings:</p> <p>A. During a review of the Resident 1 ' s Admission Record, it indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), schizophrenia (a mental illness that is characterized by disturbances in thought) and peripheral vascular disease (PVD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>During a review of the Minimum Data Set (MDS - resident assessment tool) dated 3/12/2025, indicated Resident 1 ' s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were mildly impaired. The MDS indicated Resident 1 was independent from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 5/17/2024, the H&P indicated, Resident 1 has the capacity to understand and make decisions.</p> <p>During a review of Resident 1 ' s Progress Notes dated:</p> <p>i. On 3/27/2025, the Progress Notes written by Registered Nurse 1 (RN 1) indicated, Staff approached Registered Nurse 1 (RN 1) and notify that at around 12 p.m., they witnessed Resident 1 being physically aggressive to another resident (Resident 2). The incident occurred when Resident 2 was attempting to open the patio door to go inside, Resident 1 was behind him was doing the same thing too, Resident 2 ' s action startled Resident 1 and he (Resident 1) began screaming and yelling inappropriately to Resident 2. Resident 1 started raising his fist and became physically aggressive to Resident 2 who was trying to defend himself . Resident 1 continued to scream and yell and stated that there will be a round two later.</p> <p>ii. On 4/3/2025, the Progress Notes, written by Licensed Vocational Nurse 1 (LVN 1) indicated, Resident (1) was seen arguing with another resident outside the patio. A Certified Nursing Assistant witnessed the altercation and has provided a statement . Resident 1 stated that other resident got on his personal space, and both argued about space.</p> <p>(continued on next page)</p>		

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