STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055748	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Park Healthcare	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free of accident hazards by failing to:Ensure Resident 1 was assisted with at least two-person assist during mobility and transfer according to Resident 1's Minimum Data Set (MDS - resident assessment tool).Ensure Resident 1 was evaluated and assessed by a licensed nurse after Resident 1 slipped on the floor while giving shower according to facility's policy and procedures (P&P) titled, , Falls - Clinical Protocol, and Falls and Fall Risk, Managing.This deficiency resulted in Resident 1's fall and had the potential to place the resident at risk for recurrent falls. Findings:During a review of Resident 1's Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures), muscle weakness (weakening, shrinking, and loss of muscle), muscle weakness (weakening, shrinking, and loss of muscle), abnormalities of gait (ambulation) and mobility, and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) During a review of the MDS dated [DATE], indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was severely impaired. The MDS indicated Resident 1 required total dependence (helper does all of the effort and assistance of two or more helpers is required for the resident to complete the activity) 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). During a review of Resident 1's Physical Therapy (PT) Care Plan (CP), date initiated 12/6/2025, the PT CP indicated, (Resident 1) presents with impaired: bed mobility, functional transfer, ambulation, safety awareness. reason for use: impulsive behavior, attempts to get up unassisted, poor safety awareness, inability to control body positioning. The PT CP indicated a goal of, Resident (1) will have decreased episodes of falls through review date.During a review of Resident 1's PT Evaluation and Plan of Treatment, dated 12/6/2025, the PT Evaluation and Plan of Treatment indicated that Resident 1 required maximum assistance with bed mobility and total dependence+ (td+ - referring to a patient who requires total assistance for a task but still attempts to assist with the movement).During a review of Resident 1's Occupational Therapy (OT) Evaluation & Plan of Treatment, dated 12/6/2025, the OT Evaluation & Plan of Treatment indicated that, Cognitive-Communicative Assessment: (Resident 1's) Safety Awareness was impaired. Bathing: total dependence without attempts to initiate. Upon assessment, patient (Resident 1) demonstrates significant decline in ADLs with deficits in strength, coordination, postural control, balance, functional activity tolerance, safety awareness.During a review of Resident 1's Fall Risk Assessment (FRA), dated 2/16/2026, the FRA indicated a score of 17 (total score of 10 or above represents high risk).During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/16/2026, the SBAR indicated a change of condition due to status post (s/p) fall on shower room with the Certified Nursing Assistant 1 (CNA 1). The SBAR indicated a nursing note: Called by CNA (1) to shower room, patient (Resident 1) sitting on the shower chair. Patient (Resident 1) alert and verbally responsive. Observed right cheek discoloration. Per CNA (1), patient (Resident 1) stood up and landed on right side of her face and on both knees. Discoloration observed on left and right knee.During an interview with Certified Nursing Assistant 1 (CNA 1) on 2/26/2026 at 12:19 p.m., CNA 1 stated, he (CNA 1) was assigned to Resident 1 on 2/16/2026 and he gave Resident 1 a shower in the shower room. CNA 1 stated, I transferred Resident 1 from bed to shower chair on my own, she (Resident 1) was petite and light and I was able to transfer her from bed to shower chair on my own. CNA 1 stated, during shower, Resident 1 suddenly stood up on her own from the shower chair and then she fell on both her knees and ended up on her cheeks. CNA 1 stated that Resident 1 was unable to communicate, and he (CNA 1) thought Resident 1 was unable to ambulate on her own. CNA 1 stated that after Resident 1 fell from the shower chair, he called for help and picked up Resident 1 from the floor and put her back on the shower chair. CNA 1 stated, I knew I shouldn't have done that, but I picker her up right away. CNA 1 stated that the licensed nurses must assess residents first if they fell or found them on the floor before moving the resident. CNA 1 stated that he was not supposed to lift the resident after a fall, the licensed nurse must assess resident first, but he didn't want to leave her on the floor.During an interview with Director of Rehabilitation (DOR) on 2/26/2026 at 1:05 p.m., DOR stated, Resident 1 has history of falls and required two-person assist with transfer. DOR stated that Resident 1's dynamic balance is very poor and has cognitive issues due to her diagnoses. DOR stated that it does not matter how big or small a resident is, if resident requires two-person staff assist when transferring, staff need to follow the plan of care because an accident can happen.During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/26/2026 at 1:32 p.m., LVN 1 stated, she was the charge nurse for Resident 1 on 2/16/2026 when she was called by CNA 1 for help in the shower room. LVN 1 stated, she saw Resident 1 on the shower chair after CNA 1 reported that Resident 1 fell from the shower chair. LVN 1 stated, she did not witness and she did not evaluate Resident 1 on the floor after she fell.During an interview with Director of Nursing (DON) on 2/26/2026 at 1:55 p.m., DON stated, if a resident was found on the floor, CNAs must stay with the resident until help arrives and resident must be evaluated by a licensed nurse before they move the resident. DON stated, if a resident had an accident such as fall and CNAs move the resident without being evaluated by a licensed nurse first, they can create more problems, because they won't know if resident had a fracture, etc. DON stated, it does not matter if resident is light and petite, staff must check if resident have the ability to bear weight, assess their cognition first and staff must not lift a resident on their own just because they think they can do it on their own.During a review of the facility's P&P titled, Falls - Clinical Protocol, reviewed on 11/2025, the P&P indicated that, The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happen, and observations of the events, etc.During a review of the facility's P&P titled, Falls and Fall Risk, Managing, reviewed on 5/2025, the P&P indicated that, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Environmental factions that contribute to the risk of falls include: wet floors; poor lighting; incorrect bed height or width; obstacle in the footpath; improperly fitted or maintained wheelchairs; and footwear that is unsafe or absent. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each resident at risk or with a history of falls.