| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055870 | A. Building<br>B. Wing | 08/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunray Healthcare Center | 3210 W Pico Blvd<br>Los Angeles, CA 90019 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836<br><br>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) felt safe when another resident (Resident 2) wandered into their room in the middle of the night and kissed them on the cheek. This failure resulted in Resident 1 feeling nervous and violated.<br><br>Findings:<br><br>During a review of the admission record indicated Resident 1 was initially admitted on [DATE] and readmitted on [DATE], with diagnoses that included cerebrovascular disease (conditions that affect blood flow to the brain), dysphagia (difficulty swallowing), muscle weakness, and tracheostomy (a surgical opening in the neck that provides an alternate way to breath).<br><br>During a review of Resident 1's Quarterly Minimum Data Set (MDS- a standardized assessment and screening tool) dated 5/28/2024, indicated Resident 1 had intact cognition and memory, was able to make needs known, and was able to understand others. The MDS also indicated Resident 1 was unable to ambulate and needed maximum assistance with their activities of daily living (ADL's).<br><br>During a review of the admission record indicated Resident 2 was initially admitted on [DATE] with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), nicotine dependence (smoking cigarettes), and cerebral infarction (loss of blood flow to a part of the brain).<br><br>During a review of Resident 2's Annual MDS dated [DATE], indicated Resident 2 had moderate cognitive impairment (ability to think, understand, and reason), was independent in using a wheelchair, and needed minimal supervision with their ADL's.<br><br>During a review of Resident 2's dementia care plan initiated on 11/16/2023 indicated Resident 2 had impaired cognitive function related to dementia, had impaired decision making and short-term memory loss. The goal for the resident was to develop skills to cope with cognitive decline and to maintain safety. The Interventions included the following:<br><br>1. Redirection as needed to time, place and event.<br><br>2. Administer medications as ordered.<br><br>(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: 055870 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/21/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Sunray Healthcare Center | 3210 W Pico Blvd<br>Los Angeles, CA 90019 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Communicate with the resident and family regarding the resident's capabilities.<br><br>During a concurrent observation and interview on 8/21/2024 at 8:40 AM, Resident 1 was in the room, lying in bed, awake on her cell phone. Resident 1's room was across from the facility smoking patio. Resident 1 had tracheostomy, but Resident 1 was able to speak and make needs known. Resident 1 stated on the day of the incident, Resident 1 was asleep when she felt someone kiss her on the left cheek. Resident 1 stated when she woke up, she saw Resident 2 next to her bed. Resident 2 did not speak to Resident 1 when she asked what he was doing. Resident 1 stated she immediately called a nurse, and they moved Resident 2 out of the room. Resident 1 stated that Resident 2 always greets her when he passes by her room every day and was friendly. Resident 1 stated at the time of the incident she felt nervous and felt violated because someone went into her room at night.<br><br>During a concurrent observation and interview on 8/21/2024 at 9 AM, Resident 2 was observed in their room lying in bed asleep. Resident 2 awakened to verbal stimuli and able to make needs known. Resident 2 was oriented to person but not to place or time. When Resident 2 was questioned about the incident with Resident 1, Resident 2 acknowledged that he kissed Resident 1 on the cheek. When Resident 1 was asked why he did it, Resident 1 did not give a reason.<br><br>During an interview with the Social Services Director (SSD) on 8/21/2024 at 9:10 AM, the SSD stated Resident 2 was a very social person and used his wheelchair to go around the unit. Resident 2 passes by Resident 1's room daily to go outside to smoke. The SSD stated that upon her interview with Resident 2, Resident 2 admitted to kissing Resident 1 on the cheek and stated that he did it just because. The SSD stated that Resident 2 was educated on not going into other resident's rooms or touching others without their consent. The SSD further stated that there was a potential for Resident 1 to feel unsafe and feel like her privacy and dignity had been violated.<br><br>During an interview on 8/21/2024 at 9:34 AM, the Charge Nurse (CN) stated Resident 2 was a nice and pleasant person with episodes of confusion. The CN stated she was not aware of any other incidents involving Resident 2 and the resident was being closely monitored for wandering. The CN stated that an increase in monitoring for Resident 2 could have potentially prevented the incident from occurring.<br><br>During a telephone interview on 8/21/2024 at 12:30 PM the Director of Nursing (DON) stated that Resident 2's room was in front of the nursing station, and someone would have seen Resident 2 come out of his room, as it was around 3:30 AM when the incident occurred. When asked why there was no staff who saw Resident 2 leave his room and enter Resident 1's room, the DON could not provide a reason.<br><br>During a review of the facility's policy and procedure titled, Abuse and Neglect - Clinical Protocol, revised March 2018, it indicated that instances of abuse of all residents, regardless of their mental or physical condition, can cause physical harm, pain, or mental anguish. It also indicated that sexual abuse was defined as the non-consensual sexual contact of any type with a resident. |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49836<br><br>Based on interview and record review, the facility failed to implement the individualized interventions to address the resident ' s dementia (a disorder of mental processes caused by brain disease or injury and marked by memory disorder, personality changes, and impaired reasoning) care needs for one of two sampled residents (Resident 2). This deficient practice resulted in Resident 2 wandering into another resident ' s room (Resident 1) and kissing Resident 1 on the cheek.<br><br>Findings:<br><br>A review of the admission record indicated Resident 2 was initially admitted on [DATE] with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), nicotine dependence (smoking cigarettes), and cerebral infarction (loss of blood flow to a part of the brain).<br><br>A review of Resident 2 ' s Annual Minimum Data Set (MDS) dated [DATE] indicated Resident 2 had moderate cognitive impairment (trouble with thinking, understanding, and reasoning), was independent in using a wheelchair, and needed minimal supervision with their (ADL ' s).<br><br>A review of Resident 2 ' s dementia care plan initiated on 8/16/2023 indicated the resident had impaired cognitive function related to dementia, had impaired decision making, and short-term memory loss. The care plan goal for the resident was to develop skills to cope with cognitive decline and to maintain safety. The interventions included:<br><br>-Redirection as needed to time, place and event.<br><br>-Administer medications as ordered.<br><br>-Communicate with the resident and family regarding the resident ' s capabilities.<br><br>There were no interventions regarding supervision for Resident 1 noted in the care plan.<br><br>During a concurrent observation and interview on 8/21/2024 at 9 AM, Resident 2 was in his room lying in bed asleep. Resident 2 awakened to verbal stimuli and was able to make his needs known. Resident 2 was oriented to person, but not to place or time. When Resident 2 was questioned about the incident with Resident 1, Resident 2 acknowledged that he kissed Resident 1 on the cheek. When Resident 1 was asked why he did it, Resident 1 did not give a reason.<br><br>During an interview on 8/21/2024 at 9:34 AM, the Charge Nurse (CN) stated Resident 2 was a nice and pleasant person with episodes of confusion. The CN stated she was not aware of any other incident ' s involving Resident 2 and that the resident was being closely monitored for wandering. The CN stated that an increase in monitoring for Resident 2 could have potentially prevented the incident from occurring.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Sunray Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3210 W Pico Blvd Los Angeles, CA 90019 | |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 8/21/2024 at 11:21 AM, the Director of Staff Development (DSD) stated that in the subacute unit there were two certified nursing assistants (CNA) that should be assigned. The DSD stated that she was unsure how Resident 2 entered Resident 1 ' s room without being seen by a staff member. The DSD stated Resident 2 should have been more closely supervised to prevent them from wandering into Resident 1 ' s room.<br><br>During a telephone interview on 8/21/2024 at 12:30 PM, the Director of Nursing (DON) stated Resident 2 ' s room was in front of the nursing station, and someone would have seen Resident 2 come out of their room as it was around 3:30 AM when the incident occurred. The DON was unable to give a reason as to why there was no staff who saw Resident 2 leave his room. The DON stated Resident 2 must have left his room when there was no staff at the nursing station. The DON stated there should always be at least one staff member at the nursing station to monitor the residents in case a call light goes off or a resident needs assistance.<br><br>A review of the facility policy and procedure titled, Dementia-Clinical Protocol, revised November 2018, indicated the IDT (interdisciplinary team) will identify a resident-centered care plan to maximize remaining function and quality of life. The policy indicated direct care staff will supervise and support the resident throughout the day as needed. |