

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 08/27/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>056056                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY<br>COMPLETED<br><br>06/22/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Meadows on Sunset Post Acute                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>5154 Sunset Blvd<br>Los Angeles, CA 90027 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        |                                                 |
| F 0585<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure prompt attempts were made to process and resolve the grievances for one of three sampled residents (Resident 1) when the facility failed to investigate the concern reported by Resident 1. This deficient practice had the potential to violate Resident 1's rights. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 3/19/2020, and readmitted on [DATE] with diagnoses including depression (a mental health illness causing a persistent feeling of sadness, loss of interest, and can interfere with daily life), anxiety disorder (feeling of anxiousness that affects daily life), and polyneuropathy (damage to many nerves outside the brain and spine, causing weakness, numbness, tingling, and pain, typically starting in the feet and hands). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/17/2026, the MDS indicated Resident 1 had intact cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks). The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) from facility staff with personal hygiene and upper body dressing. The MDS indicated Resident 1 was dependent (helper does all the effort) on facility staff for toileting hygiene, showers, and lower body dressing. During an interview on 6/22/2026 at 11:50 a.m. with Resident 1, Resident 1 stated that between 5/31/2026 and 6/5/2026 (Resident 1 could not recall the exact date), she (Resident 1) complained to the Certified Nurse Assistant (CNA) 1 and CNA 2 that after Resident 1's personal clothes were washed in the facility's laundry, the clothes were returned damp (slightly wet or moist) and had a moldy (may indicate active fungal spores [mildew] are growing in the fabric fibers). Resident 1 stated that she (Resident 1) informed CNA 1 and CNA 2 that her (Resident 1) personal clothes were not washed properly. Resident 1 stated that the facility staff did not address her (Resident 1) concern. During an interview on 6/22/2026 at 1:09 p.m. with CNA 1, CNA 1 stated that Resident 1 had informed him (CNA 1) that Resident 1's personal clothes, washed in the facility's laundry, smelled stale (something smells old and musty). CNA 1 stated he took Resident 1's clothes back to laundry (CNA 1 could not recall the exact date of the incident). CNA 1 stated that he did not recall discussing Resident 1's concern with other facility staff and was not sure if the issue was resolved. During an interview on 6/22/2026 at 1:35 p.m. with CNA 2, CNA 2 stated Resident 1 had informed her that Resident 1's personal clothes, washed in the facility's laundry, were still wet. CNA 2 stated that Resident 1 wanted to speak with the Charge Nurse (primary nurse for a specific unit during a single shift) to address the issue with clothes. CNA 2 stated she (CNA 2) informed the CN (can't recall the name of the CN and the exact date of the notification) that Resident 1 wanted to speak with the CN. During an interview on 6/22/2026 at 1:50 p.m. with the Social Services Director (SSD), the SSD stated that upon hearing of Resident 1's complaint regarding her (Resident 1) clothes washed in the facility's laundry, CNA 1, CNA 2, should have initiated the grievance report or informed him (SSD) to initiate the grievance process. The SSD stated Resident 1's grievance was not processed and investigation was not completed. The SSD stated Resident 1 had the right to have her concerns heard and addressed. The SSD stated the failure to process Resident 1's grievance had the (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.

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|--------------------------------------------------------------------------|-----------------------------------------|--------------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE                                   | (X6) DATE                            |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID:<br><br>Facility ID:<br>056056 | If continuation sheet<br>Page 1 of 2 |

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| F 0585<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>potential for Resident 1 to not feel satisfied with her care and feel that her concerns are not being addressed. During an interview on 6/22/2026 at 2:09 p.m. with the Director of Nursing (DON), the DON stated that CNA 1 and CNA 2 should have communicated with the SSD to address Resident 1's concerns. The DON stated the failure to process Resident 1's grievance had the potential for Resident 1 to feel that her concerns are not being addressed by the facility. During a review of the facility-provided policy and procedure (P&amp;P) titled, Resident and Family Grievances, last reviewed on 6/17/2026, the P&amp;P indicated: 4. A resident or family member may voice grievances with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and other residents, and other concerns regarding their LTC (long term care) facility stay. 8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official. 10. Procedure. b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. c. Forward the grievance form to the Grievance Official as soon as practicable. 12. The facility will make prompt efforts to resolve grievances.</p> |                                                                                        |                                                 |