STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555375	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Villa Post Acute	3232 E. Artesia Blvd. Long Beach, CA 90805

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review, the facility failed to prevent unplanned weight loss (a weight loss greater than 5 % in one month) of 24.3 pounds ([lbs.] 18.2 % percent {%}) in 40 days from 3/11/2024 to 4/20/2024 for one of three sampled residents (Resident 1). The facility failed to ensure: a. Staff identified Resident 1's decrease in oral intake (amount of food and water consumed) from 3/16/2024 to 3/27/2024 (a total of 11 days). b. The nursing staff reported a decrease in Resident 1's oral intake to Resident 1's physician (MD 1), when Resident 1 began refusing meals from 3/16/2024 to 4/1/2024 (MD 1 was notified 16 days later). c. Nursing staff followed the facility's P&P titled, Nutrition (Impaired)/ Unplanned Weight Loss- Clinical Protocol and immediately notified physician of any abrupt or persistent change from baseline appetite or food intake. d. Staff followed the Registered Dietician's (RD 2) recommendations dated 3/29/2023 which indicated to monitor Resident 1's weight and oral intake. e. Follow Resident 1's care plan titled Nutritional Risk; Resident has the potential for altered nutrition which indicated to notify physician and RD if Resident 1 refused meals and had a significant weight loss. These failures resulted in Resident 1's severe weight loss of 18.2 % in 40 days and requiring the insertion of a gastrostomy tube (G-tube- a tube inserted through the belly for food and medication administration) on 5/6/2024. These failures placed Resident 1 at risk for malnutrition (lack of proper nutrition, caused by not eating enough), dehydration (dangerous loss of body fluid), and skin break down. Findings: (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 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 1's diagnoses included metabolic encephalopathy (damage or disease that affects the brain) chronic obstructive pulmonary disease (COPD-progressive disease that makes it hard to breath), type II diabetes mellitus (a condition in which the body fails to metabolize (process) glucose (sugar) correctly), presence of right artificial hip joint (onset date, 3/14/2024), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily life). During a review of Resident 1's Care Plan titled At risk for adverse reaction (undesirable outcome) related to polypharmacy (multiple medications used by the resident) initiated on 1/23/2024, the care plan's goal indicated Resident 1 will be free from adverse drug reactions. The care plan interventions included to monitor Resident 1 for possible signs and symptoms of adverse drug reactions such as weight loss ., and poor appetite. During a review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 1/29/2024, the MDS indicated Resident 1 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 1 had no episodes of refusing care. The MDS indicated Resident 1 weighed 133 lbs and did not have any weight loss during the review period. The MDS indicated Resident 1 did not have a G-tube. During a review of Resident 1's Care Plan titled Nutritional Risk; Resident has the potential for altered nutrition initiated on 2/9/2024, had a goal to maintain adequate nutritional status as evidenced by stable weight. (goal maintenance of 133 lbs. plus (+) or minus (-) five percent [%]). The care plan interventions included to observe for signs or symptoms of malnutrition as evidenced by emaciation (abnormally thin or weak, because of illness or lack of food), refusing meals, significant weight loss, signs and symptoms of dehydration, report to physician as needed, and RD to reassess as indicated. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 was discharged for a short term stay at general acute care hospital (GACH) due to a right hip fracture (broken bone). The MDS indicated Resident 1 did not have a G-tube and weighed 139 lbs. The MDS indicated Resident 1 did not have any episodes of refusing care and only needed assistance setting up her tray during meals. During a review of Resident 1's Weights and Vitals Summary, the summary, indicated the following: On 1/23/2024 Resident 1 weigh 133.0 lbs. (mechanical lift) On 2/25/2024 138.8 lbs. (mechanical lift) On 3/11/2024 133.8 lbs. (mechanical lift) On 4/20/2024 109.5 lbs. (mechanical lift) reflecting a severe weight loss of 24.3 lbs. since 3/11/2024 (a total of 18.2% weight loss in 40 days). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Certified Nursing Assistant (CNA) documentation titled Documentation Survey Report under the interventions and tasks line, titled Amount Eaten for the month of March 2024 the Amount Eaten indicated prior to Resident 1's hospitalization on [DATE], Resident 1 was eating between 51-100% for most meals (out of 27 opportunities of meal percentages documented. Resident 1 had 17 meals where she ate 76-100%, 5 meals in which she ate 51-75%, 3 meals where she ate 26-50%, 1 meal she ate 0-25%, and Resident 1 refused 1 meal prior to hospitalization). After readmission on 3/15/2024 the Amount Eaten, indicated Resident 1 refused 5 meals, consumed 0-50% for 10 meals, and consumed 51-100% for 8 meals (out of 23 opportunities of meal percentages documented). During a review of Resident 1's Nursing Progress Notes from 3/2024 through 4/1/2024, there were no documentations addressing Resident 1's poor oral meal intake. During a review of Resident 1's History and Physical (H&P) dated 3/17/2024, MD 1 indicated Resident 1 was readmitted from the GACH, status post (after) right hip hemiarthroplasty (right hip replacement due to fracture). During a review of Resident 1's Interdisciplinary Team (IDT-team members from different departments working together with a common purpose to set goals and make decisions that ensure the resident received the best care) Conference Summary dated 3/27/2024, the IDT indicated Resident 1 was compliant with her treatment and not refusing any treatments. The IDT conference summary indicated Resident 1 had no significant weight loss, weighed 133.8 lbs. (weight taken 3/11/2024, 16 days prior) and was not receiving tube feeding. The IDT conference summary indicated a progress note from RD 2 indicated Resident 1's diet was constant carbohydrate (CCHO- diet with the same amount of carbohydrates every day to maintain good blood sugar) diet, regular texture, thin liquids, with bedtime snacks. RD 2's progress notes also indicated Resident 1's oral intake was variable (not consistent), and the average oral intake was about 60% during the last 7 days and had refused three meals. During a review of Resident 1's Nutritional Risk assessment dated [DATE] completed by RD 2, the Nutritional Risk Assessment indicated Resident 1 was readmitted from the GACH on 3/14/2024 and had no significant weight changes at that time. RD 2 recommended to add bedtime snacks and a health shake three times a day due to variable oral intake for Resident 1. The Nutritional Risk Assessment indicated to monitor Resident 1's weight and variable oral intake as needed. During a review of Resident 1's H&P dated 3/29/2024, MD 1 indicated Resident 1 was readmitted from the GACH (second admission) for right hip dislocation (hip joint out of place), and Resident 1 required a revision (second surgery) of the first right hip surgery. The H&P did not indicate Resident 1 had weight loss. During a review of Resident 1's Physician Order Summary Report, dated 4/1/2024, the Physician Order Summary report indicated an order for bedtime snacks and Health Shake NSA (a nutritional shake) three times a day (which was 5 days after RD 2 made recommendations, due to variable intake for Resident 1). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Nursing Progress Note dated 4/20/2024, the Nursing Progress Note indicated Resident 1 was monitored for poor oral intake. The note indicated Resident 1 was not eating her breakfast, snacks, lunch, or dinner. The Nursing Progress Note indicated Megace (physician order: Megestrol Acetate (a medication used to increase appetite) 20 milligram (mg- a unit of measurement) one tablet three times a day for appetite stimulation, ordered 4/18/2024 for three weeks) and Boost Nutritional drink very high calorie (530 Calories) three times a day (ordered 4/20/2024) were newly started. During a review of Resident 1's IDT Conference Summary dated 4/22/2024, the IDT Conference Summary indicated Resident 1 had a severe weight loss and weighed 109.5 lbs. (weight taken 4/20/2024). The IDT Conference Summary indicated Resident 1 had poor oral intake with a history of refusing meals and preferred to drink liquids. The IDT indicated an appetite stimulant (Megace) was started on 4/19/2024 and Resident 1's family was to visit Resident 1 to bring food from outside and see if her meal preferences could be updated. During a review of Resident 1's GACH Physician H&P dated 5/6/2024, the H&P indicated Resident 1 was admitted to the GACH for failure to thrive failure (to grow or to gain or maintain weight) and had a G-tube placement. The H&P indicated the resident was hospitalized because the condition posed a danger to Resident 1. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had a significant change in status and was readmitted from the GACH on 5/10/2024. The MDS indicated Resident 1 was moderately cognitively intact. The MDS indicated Resident 1 now had a G-tube and was receiving her nutrition via the G-tube. The MDS indicated Resident 1 was now dependent (staff did all the effort to complete the activity) on staff to complete the following activities: toileting, bathing, dressing, and personal hygiene. During a concurrent observation and interview on 7/29/2024 at 10:20 a.m., with Resident 1, in Resident 1's room, Resident 1 was lying in bed with a G-tube connected to the G-tube pump (machine that administers feeding). Resident 1 stated they feed me through my naval (belly button) and pointed towards the G-tube machine. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 7/30/2024 at 2:36 p.m., with the Quality Assurance nurse (QA), Resident 1's Documentation Survey Report under Interventions and Tasks Amount Eaten for 3/2024 was reviewed. The QA nurse stated the significant change in Resident 1's weight was identified on 4/20/2024 when she (Resident 1) went from 133.8 lbs on 3/11/2024 to 109.5 lbs on 4/20/2024. The QA nurse stated prior to Resident 1's hospitalization on [DATE], Resident 1 was consistently eating 76-100% and after she was readmitted on [DATE] she was eating less, about 0-50% on most days. The QA nurse stated there was a decrease in Resident 1's oral intake. The QA nurse stated a decrease in oral intake should be reported to the physician right away so interventions could be implemented to prevent weight loss. The QA nurse stated a change of condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) report was not done, and should have been done for the decrease in Resident 1's oral intake so the resident could be closely monitored by the RD and nursing staff. The QA stated there was no COC report done until 4/20/2024. The QA nurse stated interventions such as nutritional shakes were placed on 4/1/2024, after the recommendation from RD 2 on 3/29/2024, but a COC was not completed for monitoring. The QA nurse stated, there was no documentation to indicate the RD or MD were notified of Resident 1's weight loss or refusal to eat before 3/27/2024. The QA nurse stated Resident 1 ended up with a G-tube because of her severe weight loss, poor oral intake and refusing to eat. The QA nurse stated the facility did not follow Resident 1's care plan to inform the physician when Resident 1 was refusing meals and having poor oral intake. During a concurrent interview and record review on 7/30/2024 at 3:29 p.m., with the Director of Nursing (DON), Resident 1's Documentation Survey Report under Interventions and Tasks Amount Eaten dated 3/2024 was reviewed. The DON stated per the report, Resident 1's oral intake was decreased after her readmission on 3/14/2024. The DON stated, when Resident 1 began refusing food and consuming less during meals, the physician should have been notified. The DON stated a 24 lbs weight loss in one month was considered severe weight loss. The DON stated the potential outcome for residents with poor oral intake or refusing meals was severe weight loss and in the case for Resident 1, poor oral intake led to her needing G-tube placement. The DON stated the importance of informing the physician of meal refusals and poor oral intake was, the physician could put new orders for interventions to try and prevent weight loss and increase appetite. During an interview on 7/31/2024 at 12:30 p.m., with RD 1, RD 1 stated hospitalization and fractures (broken bone) in the elderly were risk factors for weight loss, so any resident readmitted from the hospital should be closely monitored for weight loss. The RD 1 stated decreased oral intake and meal refusals were considered a change of condition, and the RD and physician should have been notified right away so the resident could be closely monitored, and interventions could be started promptly. During an interview on 8/2/2024 at 2:05 p.m., with MD 1, MD 1 stated when Resident 1 was initially admitted to the facility on [DATE], she did not have a G-tube, but during her stay she ended up requiring G-tube placement due to failure to thrive. MD 1 stated he was not notified by the facility when Resident 1 was refusing to eat and had poor oral intake from 3/16/2024 to 3/31/2024. During a review of the facility's policy and procedure (P&P) Nutrition (Impaired)/ Unplanned Weight Loss-Clinical Protocol dated 9/2012, the P&P indicated the nursing staff was to monitor and document the weight and dietary intake of residents. The P&P indicated the staff was to report to the physician any abrupt or persistent change from baseline appetite or food intake. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled Requesting, Refusing, and/or Discontinuing Care or Treatment dated 2/2021, the P/P indicated Treatment referred to the medical care, nursing care, and interventions provided to maintain or restore the resident's health or well-being. The P&P indicated the healthcare provider needed to be notified of the refusals of treatment, in a time frame determined by the resident's condition and potential serious consequences. The P&P indicated documentation was needed in the resident's chart of the time and date the healthcare provider was notified and the practitioners response. During a review of the facility's P&P titled Change in a Resident's Condition or Status dated 2/2021, the P&P indicated the staff was to inform the resident's attending physician when there was a refusal of treatment, or a significant change (a major decline in the resident's status that will not normally resolve itself or requires interdisciplinary review and revision of the care plan) in the resident's condition. The P&P indicated such situations needed to be reported to the physician within 24 hours.