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	07/10/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to notify one of eight sampled residents (Resident 7's) physician when Resident 7 was observed with multiple open sores on her hands on 7/8/25.This failure had the potential for delayed treatment on Resident 7 multiple open sores and placed Resident 7 at risk for wound infection.Findings:During a review of Resident 7's admission Record dated 7/10/25, the admission Record indicated Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), communication deficit and encephalopathy (disturbance of brain function causing confusion and memory loss).During a review of Resident 7's History and Physical (H&P) dated 2/17/25, the H&P indicated Resident 7 could make needs known but cannot make medical decisions.During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 5/2/2025, the MDS indicated Resident 7 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 7 needs partial to moderate assist (helper does less than half the effort) with activities of daily living (ADLs- activities such as hygiene, dressing and toileting a person performs daily). During a review of Resident 7's care plan titled Resident Has eczematous dermatitis (a group of skin conditions that cause inflammation, itching, and rashes) on trunk dated 6/10/25, the care plan interventions indicated that Resident 7 was being treated with ketoconazole (used to treat serious fungal or yeast infections) 2 percent (%- unit of measure) cream apply to trunk two times a day and hydrocortisone (used to treat skin conditions) 2.5 % apply to trunk two times a-day.During a review of Resident 7's Order Summary report dated 7/01/25, the Order Summary report indicated Resident 7 was being treated with ketoconazole 2 % cream apply to trunk two times a day and hydrocortisone 2.5 % apply to trunk two times a-day.During a review of Resident 7's Occupational Therapy Treatment Encounter note dated 7/8/25, the Occupational Therapy Treatment Encounter note indicated Resident 7 had multiple small blisters (skin condition where fluid fills a space between layers of skin) on both of Resident 7's hands. The Occupational Therapy Treatment Encounter note indicated Resident 7's multiple small blisters on both hands was reported to Treatment Nurse (TX 1), and Licensed Vocational Nurse (LVN 1) and education provided to nursing staff for proper hand hygiene to minimize risk of infection. During a review of Resident 7's Physical Therapy Note, dated 7/9/25, the Physical Therapy Note indicated Resident 7 had multiple small blisters on both hands and that the charge nurse was made aware.During an observation on 7/10/25 at 10:54 am in Resident 7's room, observed Resident 7 had multiple open sores on both hands.During an interview on 7/10/25 at 10:59 am with Certified Nursing Assistant (CNA 1), CNA 1 stated that he gave Resident 7 a shower morning of 7/10/25 and noticed Resident 7 had open sores on both hands. CNA 1 stated he informed TXN 1 about Resident 7's both hands open sores after her shower.During a concurrent observation and interview on 7/10/25 at 11:19 am with TXN 1 in Resident 7's room, TXN1 stated he was informed of Resident 7's open sores on both hands on 7/10/25 but failed to assess Resident 7's hands. TXN1 stated he was focusing on the application of Ketoconazole 2% cream (antibiotic cream) on Resident 7's stomach and did not assess her hands. TXN 1 observed Resident 7's hands and stated she did have multiple open sores on both of her hands. TXN 1 stated Resident 7's medical doctor should have been called to inform Resident 7's both hands open sores. TXN 1 stated Resident 7's both hands had the potential to get infected, and the infection could spread to another resident.During an interview on 7/10/25 at11:29 am with Physical Therapist 1 (PT). PT 1 stated that she did see multiple small blisters on Resident 7's hands on 7/9/2025 and that she reported it to the Licensed Vocational Nurse 1 (LVN).During an interview on 7/10/25 at 11:35 am with LVN 1, LVN1 stated PT 1 may have told her about Resident 7's multiple small blisters to both hands but could not remember as she was too busy on 7/9/2025.During an interview on 7/10/25 at 11:50 am with Occupational Therapist 1 (OT), OT 1 stated that she had seen Resident 7 on 7/8/25 for treatment and noticed that Resident 7 had multiple blisters on both hands. OT 1 stated she informed LVN 1 and TNX 1 on 7/8/25.During an interview on 7/10/25 at 3:09 pm with CNA 2, CNA 2 stated that she had taken care of Resident 7 on 7/8/25 and observed Resident 7's both hands were red. CNA 2 stated she reported it to LVN 1 and stated LVN 1 will tell TXN 1. During an interview on 7/10/25 at 3:45 pm with the Director of Nursing (DON), the DON stated that there was a communication breakdown with her staff regarding Resident 7's multiple open sores on her hands and that Resident 7's MD should have been notified on 7/8/25 when it was first identified by OT 1. The DON stated

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS - a resident assessment tool) accurately reflects used of antipsychotic (medications- affecting the chemical messengers in the brain) medications for one of three sampled residents' (Resident 4) This deficient practice had the potential to negatively affect Resident 4's plan of care and delivery of services.Findings:During a review of Resident 4's admission Record dated 7/10/25, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (disturbance of brain function causing confusion and memory loss), diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and depression (mood disorder characterized by persistent sadness, with loss of interest in activities).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 6/5/2025, The MDS indicated Resident 4 had moderate cognitive (ability to think, understand, learn, and remember)impairment. The MDS also indicated Resident 4 was substantial/maximal assistance assist (helper does more than half the effort) with activities of daily living (ADLs- activities such as hygiene, dressing and toileting a person performs daily). The MDS also indicated Resident 4 was not prescribed any antipsychotic medication.During a review of Resident 4's Order Summary Report dated 7/10/25 the Order Summary Report indicated Resident 4 was taking Seroquel (antipsychotic medication) 25 milligrams (mg-unit of measurement) one-time a day and Seroquel 100 mg two times a day for psychosis (a severe mental condition in which thought, and emotion are so affected that contact is lost with reality) manifested by throwing food, stealing food, refusal of medications and refusal of needed ADL care.During a concurrent interview and record review on 7/9/25 at 4:31pm with the MDS Director (MDSD) , the Quarterly MDS assessment dated [DATE] and the Order Summary Report dated 7/10/25 were reviewed. The MDSD stated that Resident 4 was taking Seroquel an antipsychotic medication two times a day and that the quarterly MDS assessment dated [DATE] was not coded accurately to reflect that Resident 4 was on antipsychotic medication. The MDSD stated the MDS needs to have accurate documentation to reflect the use of antipsychotic medication to ensure if the antipsychotic medications were working. The MDSD stated that the use of any antipsychotic medications should be care plan to ensure behaviors were assessed. During an interview on 7/10/25 at 4:15 pm with the Director of Nursing (DON), the DON stated she was aware that Resident 4's MDS quarterly assessment dated [DATE] was not coded accurately to reflect Resident 4's use of antipsychotic medications. The DON stated that when the MDS was not coded accurately, the residents plan of care will not be correct, and the facility may not be providing the proper treatments for the residents.During a review of the facility's policy and procedure (P&P) titled Resident Assessments dated 2001, the P&P indicated A comprehensive assessment of every resident's needs is made at intervals designated by OBRA (federally mandated assessments) and PPS (provide information about the resident clinical condition of beneficiaries receiving Part A skilled nursing facility (SNF) level care. All people who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resident who was assessed at risk for falls, had the resident care plan revised to include the use of non-skid socks for one of three sampled residents (Resident 2). This deficient practice had the potential to increase the risk of a fall for Resident 2.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including right femur (thigh bone) fracture (broken bone), dementia (a progressive state of decline in mental abilities) and history of falling.During a review of Resident 2's History and Physical (H&P) dated 6/10/25, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions.During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 7/15/25, the MDS indicated Resident 2 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS also indicated Resident 2 needs total dependent (helper does all the effort) with activities of daily living (ADLs- activities such as hygiene, dressing and toileting a person performs daily). During a concurrent interview and record review on 7/9/25 at 12:10 pm with the Quality Assurance (QA) nurse Resident 2's Interdisciplinary team (IDT team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Notes dated 4/29/25 and Resident 2's Care plan titled Resident is at risk for falls dated 12/11/24, revised on 6/9/25 were reviewed. The QA nurse stated there was a recommendation made after the IDT meeting on 4/29/2025 for Resident 2 to wear non-skid socks during ambulation, after Resident 2 had an unwitnessed fall in the hallway. The QA nurse stated the recommendation for non- skid socks was not carried over to Resident 2's risk for falls care plan. The QA nurse stated Resident 2 was high fall risk and the IDT recommendation for non- skid socks was still relevant and should have added to Resident 2's care plan and implemented. During an interview on 7/10/25 at 4:15 pm with the Director of Nursing (DON), the DON stated Resident 2 was a high fall risk and that she was made aware that the IDT recommendation for non-skid socks on 4/29/25 was not on Resident 2's at risk for falls care plan. The DON stated the recommendations made during the IDT meeting should have been part of Resident 2's plan of care to help prevent any further falls.During a review the facility's policy and procedure titled Care Plans - Comprehensive dated 9/2010, the P&P indicated Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying sources of the problem areas. Identifying problems areas and their cause and developing interventions that are targeted and meaningful to the residents are interdisciplinary processes that require careful data gathering. The care plan IDT team is responsible for the review and updating of care plans when there is a significant change in the resident's condition, when the desired outcome was not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of three sampled residents (Resident 1's) who was on Enhanced Barrier precautions (EBP- infection control measures to reduce the spread of multidrug-resistant organisms (MDRO's) for the use of a midline (a long peripheral catheter inserted into a vein) was implemented when toileting Resident 1.This deficient practice placed Resident 1 at risk for possible worsening of her infection. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including, hypertension (high blood pressure), communication deficit and metabolic encephalopathy (disturbance of brain function causing confusion and memory loss).During a review of Resident 1's History and Physical (H&P) dated 6/28/25, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 7/3/2025, The MDS indicated Resident 1 had severe cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 1 needs substantial/maximal assistance assist (helper does more than half the effort) with Activities of Daily Living (ADLs- activities such as hygiene, dressing and toileting a person performs daily). The MDS also indicated Resident 1 was always incontinent (no control of urine or bowel movements) of bladder and bowel.During a review of Resident 1's Order Summary Report dated 7/10/25, the Order Summary Report indicated Resident 1 had orders to monitor Resident 1's intravenous (IV-giving medicines or fluids through a needle or tube inserted into a vein) peripheral site every shift for signs/symptoms of infection and/or infiltration (leakage of intravenous (IV) fluids or medications into the surrounding tissue). The Order Summary Report also indicated Resident 1 was receiving Vancomycin (antibiotic) IV 800 milligrams (mg- unit of measure) two times a day.During a review of Resident 1's care plan titled Enhanced Barrier Precautions, dated 7/6/25, the care plan indicated Resident 1 required EBP during high contact resident care activities. The care plan also indicated staff were to utilize personal protective equipment (PPE- gown and gloves, face shield) during high contact resident care activities such as changing brief (diaper) and toileting assistance. The care plan indicated that notification/signage near the resident's room doorway to alert staff/resident of the precautions.During an observation on 7/8/25 at 1: 09 pm in Resident 1's room, Resident 1 was observed with a midline to her right upper arm (RUA) and no sign outside of Resident 1's door or above her bed indicating Resident 1 was on EBP.During an interview on 7/8/25 at 4:00 pm with Certified Nursing Assistant (CNA) 3 in Resident 1's room. CNA 3 stated he was taking care of Resident 1 and that she was not on EBP. CNA 3 stated it was Resident 1's roommate that was on EBP because the licensed nurse came into the room about 40 minutes (min) ago and put the six moments of EBP (when to use PPE) sign up over Resident 1's roommates' bed. CNA 3 stated he did not remember what the six moments of EBP was because he did not get a report from the licensed nurse yet.During an observation on 7/8/25 at 4:09 pm in Resident 1's room CNA 3 observed not taking PPE into Resident 1's room prior to shutting the door to toilet Resident 1.During an interview on 7/10/25 at 3:16 pm with CNA 3, CNA 3 stated that Resident 1 was on EBP for her IV site and that he should have worn PPE when toileting Resident 1 on 7/8/25 to protect resident from infection. During an interview on 7/10/25 at 3:43 pm with the Infection preventionist (IP). The IP stated Resident 1 was on EBP for her RUA midline site and that before staff were to provide direct care to Resident 1, they need to wear PPE (a gown and gloves). The IP stated Resident 1 was at risk of infection and staff needed to wear PPE when performing high contact resident care activities. During an interview on 7/10/25 at 4:15 pm with the Director of Nursing (DON) the DON stated she was made aware that CNA 3 did not wear PPE while toileting Resident 1 and that he should have because Resident 1 did have a midline in her right arm and on EBP. The DON stated wearing PPE was important to help minimize the spread of infection.During a review the facility's policy and procedure titled Enhanced Barrier Precautions dated 2001, the P&P indicated EBPs are utilized to prevent the spread of multi -drug resistant organisms (MDROs) to residents during high contact resident care activities. Residents with indwelling medical devices including central lines, urinary catheters, gown and gloves are applied prior to performing high contact resident care activity (as opposed to before entering the room).