

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555375	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Sunset Villa Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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) who had poor safety awareness (a resident's inability to recognize physical dangers and follow safety instructions, which puts them at risk for injury - especially during mobility and self-care activities), a history of a falls, and was a moderate risk for falls, was supervised by the nursing staff while seated in her wheelchair. The facility failed to: 1. Ensure the nursing staff promptly provided redirection and cueing (the use of verbal, visual, or tactile prompts to guide a resident's behavior or actions in a safe and appropriate manner) to prevent Resident 1 from getting up from her wheelchair unattended. 2. Ensure the nursing staff followed the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Resident, indicating the importance of ensuring interventions are implemented correctly and consistently. This deficient practice resulted in Resident 1 getting up from her wheelchair and falling to the floor. Findings: During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including unspecified mood disorder (mental health condition characterized by significant and prolonged changes in mood, impacting a person's ability to function daily), cognitive communication deficit (problem with thinking and communicating, often caused by brain injuries, strokes, or other neurological conditions) and displaced intertrochanteric fracture of right femur (break in the upper part of the thigh bone [femur], near the hip joint). During a review of Resident 1's History and Physical (H/P), dated 9/4/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 9/9/2025, the MDS indicated Resident 1's cognitive skill for daily decision-making were severely impaired. The MDS indicated Resident 1 was fully dependent on staff for toileting hygiene, showering, upper and lower body dressing. During a review of Resident 1's Fall Observation Assessment (standardized method used to identify a resident's risk of falling, based on specific risk factors), dated 9/3/2025, the assessment indicated Resident 1 was a moderate risk for falls. During a review of Resident 1's Occupational Therapy Evaluation and Plan of Treatment, dated 9/4/2025, indicated Resident 1 had impairments in mobility, strength, attention, follow-through, planning and problem-solving, resulting in limitations in areas of self-care and mobility. During a review of Resident 1's Care Plan initiated 9/4/2025, the Care Plan indicated Resident 1 was at risk for falls with or without injury related to cognitive impairment, history of fall, right hip fracture, anemia (condition where your blood doesn't have enough healthy red blood cells to carry oxygen to the body's tissues), mood disorder and episodes of attempting to get up unassisted. The Care Plan indicated the following goal will minimize complications related to fall to extent possible. The Care Plan interventions indicated the following, place resident in the nurses' station for supervision. During a review of Resident 1's Change of Condition ([COC] significant shift in a person's health or functional abilities) Evaluation, dated 9/25/2025, indicated while in bed, Resident 1 attempted to stand up without assistance using the over the bed TV mount for support causing resident to fall and hit her forehead. During a review of Resident 1's Interdisciplinary Team ([IDT] team of healthcare professionals who work together to develop and implement a resident's care plan) note, dated 9/25/2025, the note indicated the IDT met to discuss ongoing behavioral concerns which included Resident 1's repeated episodes of attempting to get up unassisted and behaviors have persisted despite redirection efforts. The note indicated Resident 1's Responsible Party (RP) was present during the IDT meeting. During a review of the facility's Witness Fall Report, dated 9/26/2025, indicated Registered Nurse (RN) 1 stated on 9/26/2025 at approximately 3:15 p.m., while at the nurses' station, she heard Certified Nurse Assistant (CNA) 1 in the hallway telling Resident 1 to sit down. RN 1 then saw Resident 1 had fallen to the floor as CNA 1 approached her (Resident 1). During a continued review of the facility's Witness Fall Report, dated 9/26/2025, indicated CNA 1 stated on 9/26/2025, she was walking down the hallway when she saw Resident 1 stand up from her wheelchair. CNA 1 reported that she ran toward Resident 1 while shouting for her to stop but was unable to reach her in time. CNA 1 stated Resident 1 fell to the floor and landed on her right side. During a review of Resident 1's COC Evaluation, dated 9/26/2025, the COC indicated Resident 1 was sitting in a wheelchair in the hallway when she stood up unassisted from her wheelchair, took a step and fell to the floor and landed on her right side. The COC indicated Resident 1 was transferred to the GACH for further evaluation. During an interview on 11/19/2025, at 11 a.m., RP 1 stated on 9/25/2025, Resident 1 hit herself on the head with the TV mount during an attempt to get out of bed unassisted. RP 1 stated on 9/26/2025</p>		