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	02/10/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the licensed nurses documented vital signs and nursing interventions when a resident (Resident 1) was coughing up blood, for one of four sampled residents (Resident 1). This deficient practice resulted in missing documentation indicating care that was given to Resident 1 and had the potential for Resident 1's progress during a change of condition to be undetermined and/or unidentified and the provision and/or escalation of his care to be delayed.Findings:During a review of Resident 1's admission Record (Face Sheet), the Face Sheet indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebrovascular disease (a condition that interfere with blood flow to the brain, which can lead to problems like stroke or brain damage) and seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool) dated 5/23/2025, the MDS indicated Resident 1 was unable to make decisions that were reasonable and consistent.During a review of Resident 1's Medication Administration Record ([MAR] a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 1/2026, the MAR indicated an order was placed for Resident 1 to receive Eliquis 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube two times a day, ordered on 11/14/2025. The MAR indicated the last dose of Eliquis was administered to Resident 1 on 1/4/2026 at 6 a.m. During a review of Resident 1's Care Plan, initiated 11/17/2025, the Care Plan indicated Resident 1 was at risk for potential bleeding and bruising due to anticoagulant therapy. The Care Plan's goal was for Resident 1's signs and symptoms of bleeding to be identified and attended promptly with interventions to alleviate bleeding in a timely manner with interventions including assessing Resident 1 for signs signifying blood loss and notifying the physician if observed, monitoring Resident 1 frequently for signs of neurological (the functioning of the brain, nerves and the spine) impairment (a condition of being weak, loss of function or damaged), bleeding and to report abnormal findings to the physician.During a review of Resident 1's SBAR ([situation, background, assessment, recommendation] a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 1/4/2026 and timed at 8:40 a.m., the SBAR indicated Resident 1 was coughing up blood and his blood pressure (is the pressure of blood against the blood vessels as it moves throughout the body) was 163/97 millimeters of mercury ([mmHg] a standard unit of measurement for pressure specifically for blood pressure (normal range of less than 120/80 mmHg)).During a review of Resident 1's Progress Notes (Nurse's Notes) dated 1/4/2026 and timed at 9:02 a.m., the Nurse's Notes indicated Resident 1 was coughing a moderate amount of blood and had a blood pressure of (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	163/97. The Nurses' Note indicated Resident 1's attending physician was informed, and orders were received to transfer Resident 1 to a General Acute Care Hospital (GACH). During a review of Resident 1's Progress Notes (Nurse's Notes) dated 1/4/2026 and timed 9:04 a.m., the Nurse's Notes indicated a private ambulance ([BLS] basic life support transport, when a patient is transferred by Emergency Medical Technicians [EMTs] who provide non-invasive, basic medical care during ambulance transport) was called by the facility with an expected arrival time between 11:30 a.m. to 12 p.m.During a review of Resident 1's Progress notes (Nurse's Notes) dated 1/4/2026 and timed at 12:05 p.m., the Nurse's Notes indicated Resident 1 was coughing more blood, his jaw was clenched and required continuous oral suctioning. The Nurse's Notes indicated the private ambulance crew on scene advised the facility licensed staff to call 911 as Resident 1 required an emergency transfer to the GACH. The Nurse's Notes indicated Resident 1 was transferred to GACH by the paramedics (a group of individuals trained to provide emergency medical care to people who are injured or ill outside the GACH) on 1/4/2026 at 11:57 a.m. During a review of Resident 1's Weights and Vitals Summary (essential measurements taken by the healthcare team providers to check the body's most basic and life sustaining functions), dated 1/4/2026, the Weights and Vital Summary indicated the licensed nurses documented Resident 1's vital signs during his change of condition which included the following: 1. At 8:27 a.m., Resident 1 had body temperature of 97.8 Fahrenheit, a temperature scale used that measures how hot or cold it feels to humans), blood pressure of 163/97 mmHg, heart rate of 74 beats per minute (BPM), and respiratory rate (the number of breaths) of 19 breaths per minute.2. At 11:46 a.m., Resident 1 had a body temperature of 97.8 Fahrenheit, blood pressure 162/92 mmHg, heart rate of 72 (BPM), respiratory rate of 18 breaths per minute.During a review of Resident 1's Progress Notes and Vital Signs Summary, dated 1/4/2026, there was no documentation indicating Resident 1 was monitored or that vital signs were taken by the licensed nurses on 1/4/2026 at 8:40 a.m. when he was coughing blood.During a review of the Paramedic Run Sheet (an official medical report completed by emergency medical services (EMS) personnel that documents everything that happened during a 911 medical response) dated 1/4/2026 and timed at 11:47 a.m., the Paramedic Run Sheet indicated the private ambulance crew who were onsite at the facility called the paramedics for an emergent transfer of Resident 1 to GACH. The Paramedic Run Sheet indicated Resident 1 was seen by the paramedics with uncontrolled bleeding from his mouth due to a bite on his tongue and he (Resident 1) had a blood pressure 162/94 mmHg, heart rate of 70 BPM, respiratory rate of 20 breaths per minute and an oxygen saturation (a measurement of how much oxygen the blood is carrying to support the heart and the lungs and the organs throughout the body) of 96 % (unspecified if on room air or with oxygen supplementation). The Paramedic Run Sheet indicated Resident 1 was continuously suctioned by the paramedics from his mouth in route to the GACH and they filled three suction canisters estimating to 800 to 1,000 milliliters ([mL] a unit to measure liquid volume) of blood.During a review of Resident 1's GACH Records (Emergency Department [ED] Notes) dated 1/4/2026 and timed at 12:33 p.m., the ED Notes indicated Resident 1 presented to the GACH's ED with profuse bleeding from the tongue and a blood pressure of 184/108 mmHg. The ED Notes indicated Resident 1 was admitted for a 24-hour observation and was given one liter of intravenous (a way to administer fluids, medicine, nutrition or blood directly into the blood stream through a vein) fluids for mild tachycardia (a condition when the heart is beating much faster than normal usually more than 100 beats per minute), nebulization (a simple and effective method of delivering liquid medication directly into the lungs as a fine mist or aerosol) of Tranexamic acid (a medication used to stop or prevent heavy bleeding) and intravenous infusion of tranexamic acid 1 gram (a unit of weight of metric system used to measure how heavy something is) for eight hours.During a telephone interview on (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/5/2026 at 1:37 p.m., Certified Nursing Assistant (CNA) 1 stated on 1/4/2026 at around 8 a.m., she observed Resident 1 was moderately bleeding around his mouth and bright red blood was dripping down his chin. CNA 1 stated she informed Licensed Vocational Nurse (LVN) 2 and she and LVN 2 cleaned Resident 1 and LVN 2 checked Resident 1's vital signs. CNA 1 stated she did not see LVN 2 inspect Resident 1's mouth and/or check the bleeding. CAN 1 stated before 11 a.m., while she was doing her rounds, she observed Resident 1 was coughing a lot of blood from his mouth, did not look right, and was uncomfortable. CNA 1 stated she and LVN 2 cleaned Resident 1 a second time then observed LVN 2 check Resident 1's vital signs but did not see LVN 2 attempt to suction Resident 1's secretions/bleeding from his mouth. During a telephone interview on 2/5/2026 at 1:55 p.m., LVN 2 stated Resident 1 had only one episode of vomiting of mild bright red blood on 1/4/2026 at around 8 a.m. LVN 2 stated she monitored Resident 1's condition and checked his vital signs while waiting for the private ambulance, but she did not document her findings. LVN 2 stated she could have recorded Resident 1's progress, vital signs and interventions on the Nurse's Notes to track Resident 1's actual progress and/or deterioration, if any, and most importantly to send him quickly to GACH because of his bleeding. During a telephone interview on 2/5/2026 at 2:22 p.m., Registered Nurse Supervisor (RNS) 2 stated she was summoned by LVN 2 on 1/4/2026 at around 8 a.m. and observed Resident 1 having a medium pool of blood on his face and gown. RNS 2 stated it was unable to determine Resident 1's source of bleeding from his mouth and could not suction Resident 1's secretions. RNS 2 stated she monitored Resident 1's condition and checked his vital signs, while waiting for the private ambulance and there was no other incidence of bleeding after that. RNS 2 stated when the private ambulance crew arrived around 11:30 a.m., Resident 1 had another episode of bleeding from his mouth and the ambulance crew suctioned Resident 1's mouth and the blood that was suctioned immediately filled the suction cannister. RNS 2 stated she did not document Resident 1's progress and monitoring in the Nurse's Notes because she was unsure of the facility's policy on reassessment and monitoring during a change of condition. RNS 2 stated she was not aware of Resident 1's medications and side effects of bleeding. RNS 2 stated she could have documented her assessments and/or reassessments and monitoring of Resident 1 who was bleeding to include his vital signs and all other nursing interventions that she did so she can identify if Resident 1's condition was worsening. RNS 2 stated she also could have verified Resident 1's medication list and identify possible adverse reactions and side effects that could have worsened the bleeding and escalated Resident 1's transfer to GACH by calling 911, instead of waiting for the private ambulance.During an interview on 2/6/2026 at 12:30 p.m., the Director of Nursing (DON) stated RNS 2 and LVN 2 could have reassessed and/or monitored Resident 1 thoroughly and provide nursing interventions to identify Resident 1's source and severity of bleeding, and to check Resident 1's list of medications that aggravate bleeding. The DON stated LVN 2 and RNS 2 could have documented Resident 1's monitoring and vital signs in the medical record to ensure tracking of Resident 1's progress as this was an important basis of information to call the primary physician, escalate Resident 1's care and prevent complications of hemorrhage (severe or rapid blood loss caused by damaged blood vessels) and hypovolemic shock (a life threatening emergency caused by losing 20% or more of the body's blood or fluid supply, caused by but not limited to, trauma, severe and internal bleeding).During a telephone interview on 2/6/2026 at 2:18 p.m., Resident 1's Attending Physician (AP) stated Resident 1 was prescribed Eliquis to prevent a stroke and the side effect of the medication is profuse (large amount) bleeding. AP stated on 1/4/2026, he was initially informed by the licensed nurses of Resident 1's bleeding with stable vital signs and he ordered Resident 1 to be transferred to a GACH where he can follow Resident 1's care. AP stated he expected the licensed nurses to monitor Resident 1, who was (continued on next page)

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