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	04/22/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an outside activity provider, who was contracted by the facility to provide activity's to residents', was monitored by the facility to ensure the activity provider did not videotape six out of sixteen residents (Residents 6, 10, 11, 12 13, and 14) without the resident's and/or their representative's consent and the outside activity provider did not include in their program disparaging (criticizing, belittling, or undervaluing someone, often in a way that shows a lack of respect or aims to diminish their reputation) remarks towards the residents. These deficient practices resulted in Residents 6, 10, 11, 12, 13, and 14, who had different levels of cognitive impairment (a condition when a person has trouble with mental tasks such as memory, learning, concentration or decision making), unknowingly and without permission being videotaped during an activity program while the contracted activity provider teased and mocked the residents and later posted identifiable images of the residents on multiple social media outlets. These deficient practices had the potential for residents loss of privacy and dignity, embarrassment and loss of trust in staff.Findings: a. During a review of Resident 6's admission Record (Face sheet), the Face sheet indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6 had diagnoses that included metabolic encephalopathy (a disease that affects the brain leading to confusion), and dementia (a progressive state of decline in mental abilities). During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool) dated 4/14/2026, the MDS indicated Resident 6 was forgetful and was not able to make consistent and reasonable decisions. Resident 6 required a one-person assist to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 6's Skilled Nursing Facility Progress Note dated 1/23/2026, the Skilled Nursing Facility Progress Note indicated Resident 6 was able to make medical decisions with her brother's assistance. b. During a review of Resident 10's admission Record (Face sheet), the Face sheet indicated Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 10 had diagnoses including metabolic encephalopathy, psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and depression (a mood disorder characterized by persistent sadness that interferes with daily life, work and relationships). During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 was unable to make reasonable and consistent decisions. Resident 10 required a one-person assist to complete his ADLs. c. During a review of Resident 11's admission Record (Face sheet), the Face Sheet indicated Resident 11 was initially admitted to 11/14/2001 and readmitted on [DATE]. Resident 11 had diagnoses including metabolic encephalopathy and dementia. During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 was unable to make decisions that were reasonable and consistent. Resident 11 required a two person assist to complete her ADLs. During a review of Resident 11's History and Physical (H&P) dated 3/20/2026, the H&P indicated Resident 11 had a fluctuating capacity to understand and make decisions. d. During a review of Resident 12's admission Record (Face sheet), (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Face sheet indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted om 11/20/2025. Resident 12 had diagnoses including psychosis, and dementia. During a review of Resident 12's MDS dated [DATE], the MDS indicated Resident 12 was forgetful and was not able to make consistent and reasonable decisions. Resident 12 required a one person assist to complete her ADLs. During a review of Resident 12's Physician's Progress Note dated 4/7/2026, the Physician's Progress Note indicated Resident 12 had no capacity for medical decision making due to dementia. e. During a review of Resident 13's admission Record (Face sheet), the Face Sheet indicated Resident 13 was initially admitted to the facility on [DATE] and readmitted [DATE]. Resident 13 had diagnoses including anoxic brain damage (when oxygen is cut off completely to the brain), and psychosis. During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 was forgetful and was not able to make consistent and reasonable decisions. Resident 13 required a one person assist to complete his ADLs. During a review of Resident 13's H&P dated 12/9/2025, the H&P indicated Resident 13 did not have a capacity to understand and make decisions. f. During a review of Resident 14's admission Record (Face [NAME]), the Face sheet indicated Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14 had diagnoses including encephalopathy and psychosis. During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 was able to make decisions that were reasonable and consistent. During a review of Resident 14's H&P dated 1/4/2026, the H&P indicated Resident 14 had the capacity to understand and make decisions. During a review of an Instagram ([IG] commonly known as Reel is a short engaging video clip shared through a social media platform designed for quick viewing similar to TikTok) Video dated 3/15/2025, the IG video indicated Resident 10 was sitting in his wheelchair in the presence of the contracted activity provider and eight other unidentified residents. The contracted activity provider was engaged in a conversation with two residents (a female and a male) and was heard saying listen couple, listen hot stuff, you are interrupting my show, it's rude, if you want to take her out, take her outside. The video indicated the male resident told the female resident Shake that pussy! The contracted activity provider laughed and was heard saying he mentioned shake that pussy instead of shake that tushy. Continued review of the IG video showed no indication that staff at the facility intervened during the inappropriate conversation between residents and/or the contracted activity provider. During a review of IG Video dated 3/16/2026, the IG video indicated Resident 10 was sitting in his wheelchair in the presence of eight unidentified residents, when the contracted activity provider was heard rapping hey shake that tushy, eat a cookie, yeah shake it doll, shake it at the mall, shake it doll in the bathroom stall. During a review of an IG Video dated 3/17/2026, the IG video indicated Resident 10 and Resident 11 were sitting in their wheelchairs in the presence of 14 unidentified residents when the contracted activity provider was heard rapping do the finger dance, can't get up that's fine, put your fingers up real high, move it from side to side, yeah [NAME] looking real fly, shake them fingers don't be shy, you got arthritis common just try. The contracted activity provider then pointed to an unidentified male resident and said Oh, my God he's got no finger? Perfect, I love that he's making do. During a review an IG Video dated 3/24/2025, the IG video indicated there were six unidentified residents attending the activity program and the contracted activity personnel was rapping, Gramps in his wheelchair cruising, but the bandage on his head is oozing, call the nurse over here to clean him up, all my walkers in the front row stand up, got a drink in your hand drop that cup, put your hands on the bar you know what's up, for those people who can't get out of bed, put your fingers up you ain't dead. During a review of an IG Video dated 4/29/2026, the IG video indicated Resident 6 was sitting in her wheelchair, in the presence of seven unidentified residents, when the contracted activity provider was heard rapping crockpot, make some chicken stew, throw it all into the crockpot, then it's all cooked boo, hot, hot. After completing the rap song, the contracted activity provider was heard saying, I am so distracted by [NAME]. During a review of an IG Video dated 5/25/2025, the IG Video indicated the contracted activity provider in the presence of Resident 6 and five unidentified residents was heard rapping I stalk my boyfriend it's not a big deal, call me a creep I (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	am just keeping it real, I am just kidding no way, I only stalk during the day. Resident 6 was seen walking to and then holding hands with the contracted activity provider as they danced. During a review of a TikTok Video (a short form of video created, edited and shared through a social media platform designed for a quick entertainment featuring dances, comedy, educational hacks and lip-syncs) dated 7/30/2025, the TikTok video indicated Resident 12 danced while the contracted activity provider was heard rapping, don't need a cane to make you sway, turn this bingo hall into a cabaret, hot like soup like an early bird, making them purr without saying a word, who's having their fourth marriage, where's the [NAME], don't take your diaper off just move it to the side. Resident 10, Resident 11, Resident 13 and Resident 14 were seen in the TikTok video sitting in their wheelchairs along with 12 unidentified residents. During a review of a TikTok Video dated 8/11/2025, the TikTok video showed Resident 12 dancing with the contracted activity provider who was heard rapping, we are all gonna die I am giving you a pass, yeah pass that gas, I ain't judging, you can't remember the date or time, you are like a VHS tape on rewind, so what doll you're losing your mind, let's show these youngins' how we bust and grind, put your hands in the air if you got that gray hair even if it's down in there who cares, embrace your age if you dare, do a wheelie in that wheelchair, we are all gonna die let's dance maybe our last chance. Resident 10, Resident 11, Resident 13 and Resident 14 were seen on the TikTok video sitting in their wheelchairs and Resident 6, was standing by the side of the dining room, waving her hand. The video indicated there were 3 facility staff present (Activity Assistant [AA] 1, 2, and 3) in the dining room during the activity. During a review of a TikTok Video dated 8/13/2025, the TikTok Video indicated a contracted activity provider was heard rapping, she loves the elderly and children because they don't judge and are innocent, their teeth fall out some grow back in and both wear diapers they like to pee in, both get food in their chin- chin, don't touch their happy meal or pill bin, they eat healthy lunch, both are blended because they can only [NAME]. Resident 10 and Resident 11 were seen in the TikTok video sitting in their wheelchairs, while Resident 6 was dancing beside the contracted activity provider. During an interview on 4/21/2026 at 12:43 p.m., Resident 6 stated during the birthday month celebration (cannot remember the dates) there was a lady who performed rapping for the residents. Resident 6 stated there were facility staff (unknown) in the dining/activity room during the performance who were taking videos of her dancing with the lady performer (contracted activity provider). Resident 6 stated no one asked her if it was okay for her to be filmed. During an interview and concurrent record review on 4/21/2026 at 2:03 p.m., Restorative Nurse Assistant (RNA) 1 stated Resident 6, Resident 10, Resident 11, Resident 12, Resident 13 and Resident 14 were amongst the identified residents in the TikTok and IG Videos. RNA 1 stated there were three AAs (AA 1, 2 and 3) in the video on 8/11/2025. RNA 1 stated videotaping of the residents without consent is not allowed in the facility. During an interview on 4/21/2026 at 3:18 p.m., the Activity Director (AD) stated she hired the contracted performers for the residents' activities, but she only discussed the rate of pay with them during a telephone conversation. The AD viewed the TikTok and IG Videos, and stated videotaping of residents should not have happened without consent of the residents and/or their responsible party (RP). The facility's activity staff should have stopped the videotaping and protected the resident's privacy. During an interview on 4/22/2026 at 9:58 a.m., Resident 12 stated the performer (contracted activity provider) and her were dancing in the dining room in front of other residents and staff on different dates during birthday celebrations (dates unknown) and somebody videotaped her and the contracted activity provider dancing. Resident 12 stated she did not feel right about being videotaped because she did not give permission, but she did not stop the videotaping because she saw the residents and the staff were very happy. During an interview on 4/22/2026 at 10:56 a.m., the Director of Staff Development (DSD) stated the activity staff and any other staff present during the contracted activity provider performance should have monitored the residents' and the contracted activity provider to ensure there was no unpermitted videotaping of the residents. The DSD stated this should not have happened because there were AAs present during resident activities at all times. During an interview on 4/22/2026 at 12:06 p.m., the (continued on next page)

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