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	05/27/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled resident's (Resident 2) call light (device that allows residents to request assistance from nursing staff) was accessible and within reach.This failure resulted in Resident 2 being unable to summon staff for needed assistance and had the potential to result in delayed response, unsafe attempts to self^transfer, and falls.Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 was admitted to the facility with diagnoses including metabolic encephalopathy (temporary or permanent damage to the brain due to lack of glucose, oxygen, or other metabolic agent, or organ dysfunction), abnormalities of gait and mobility (difficulty walking or moving in a normal, steady, or coordinated way), and dementia (a progressive state of decline in mental abilities) with agitation (restless, upset, or inability to stay calm).During a review of Resident 2's History and Physical (H&P), dated 1/11/2026, the H&P indicated Resident 2 did not have the capacity to make medical decisions.During a review of Resident 2's Minimum Data Set ([MDS] a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired and required maximal assistance (helper does more than half the effort) from staff for toileting, bathing, and personal hygiene. The MDS indicated Resident 2 required a wheelchair for mobility and was always incontinent of bowel and bladder (involuntary voiding of urine and stool).During a review of Resident 2's untitled Care Plan dated 1/12/2026, the Care Plan indicated Resident 2 had an alteration in musculoskeletal status related to left wrist pain and edema (swelling), amputated (surgical removal of a body part) third digit, and gout (a form of inflammatory arthritis that develops in some people who have high levels of uric acid in the blood). The Care Plan's interventions indicated anticipating and meeting the needs of Resident 2, ensuring the call light was within reach, and respond promptly to all requests for assistance. During a review of Resident 2's untitled Care Plan dated 1/12/2026, the Care Plan indicated Resident 2 was at risk for an Activities of Daily Living ([ADL] activities such as bathing, dressing and toileting a person performs daily)/Mobility Decline and requires assistance. The Care Plan's interventions indicated encouraging Resident 2 to use the call light for assistance.During a review of Resident 2's untitled Care Plan dated 5/20/2026, the Care Plan indicated Resident 2 had a witnessed fall on 5/19/2026. The Care Plan's interventions indicated to anticipate and meet Resident 2's needs, educate and remind Resident 2 to call for assistance, and keep the call light within reach.During a concurrent observation and interview on 5/26/2026 at 3:37 p.m., with Resident 2, while in Resident 2's room, Resident 2 was observed lying in bed yelling out for help. Resident 2's call light was observed not within reach and was coiled behind his headboard. Resident 2 stated he had to yell out to get assistance. Resident 2 stated it took nursing staff over 30 minutes to respond. Resident 2 stated staff were supposed to help him, but staff did not come all the time. Resident 2 stated he was very aggravated. Resident 2 stated, How can I get to the bathroom if I cannot get up? Resident 2 stated staff did not help him get out of bed and he would have to get up by himself. Resident 2 stated he had trouble with his feet and needed assistance to get up. Resident 2 stated if staff did not come (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soon, he would have to stand out in the hallway and yell for help.During a concurrent observation and interview on 5/26/2026 at 4:11 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 was incontinent of bowel and bladder and did not always state specific needs. LVN 1 acknowledged and stated Resident 2's call light was out of Resident 2's reach and should not have been behind the headboard. LVN 1 stated Resident 2 needed access to the call light to receive care in a timely manner. LVN 1 stated the call light helped prevent falls because Resident 2 attempted to get up when staff did not respond. LVN 1 stated staff needed to check Resident 2 because he could not always express his needs.During a review of the facility's policy and procedure (P&P) titled Answering the Call, revised January 2026, the P&P indicated the purpose of the call light was to ensure timely responses to residents' requests and needs. The P&P indicated the call light was to be plugged in and functioning at all times. The P&P further indicated staff would ensure the call light was accessible to residents while in their bed, from the toilet, from the shower or bathing facility and from the floor.