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	06/23/2026

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident (Resident 1) who's room was changed, received advance written notice including the reason for the room change, exercised his right to refuse the room change, had the opportunity to sign the room-change notice, and was provided a copy of the notice for one of three sampled residents (Resident 1). This failure resulted in Resident 1 not being given the option to accept or decline the room change and resulted in Resident 1 feeling frustrated, irritated, and disappointed after the room change.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 had diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a type of stroke caused by a blockage of blood flow in the brain) affecting the right dominant side. The admission Record indicated Resident 1 was self^responsible.During a review of Resident 1's History and Physical (H&P) dated 3/30/2026, the H&P indicated Resident 1 did not have the capacity to make medical decisions.During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 4/3/2026, the MDS indicated Resident 1's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. During a review of Resident 1's Notice of Room Change, dated 5/29/2026, the Notice of Room Change indicated Resident 1's room change was needed for a new admission, and the room change was not medically necessary, and that Resident 1 preferred to give a verbal consent instead of a signature. The Notice of Room Change indicated staff were to print the form for the resident or resident representative to sign as written notice, and once signed, upload the signed document into the resident's Electronic Health Record.During a review of Resident 1's Progress Notes, dated 5/29/2026, there was no documentation indicating Resident 1 was informed of his right to refuse the room change.During a review of Resident 1's Social Services Notes, dated 5/29/2026, there was no documentation indicating Resident 1 was notified in advance and agreed to the room change. During a telephone interview on 6/18/2026 at 10:28 a.m., with Family Member (FM) 1, FM 1 stated Resident 1 had been in one room, and facility staff had come into his room and informed him he was going to be moved without advance notice. FM 1 stated neither she nor Resident 1 had received advance notice of the room change. FM 1 stated staff had told Resident 1 another resident needed to be in his room so the other resident could be closer to the nursing station. FM 1 stated after the move she noticed a change in Resident 1. FM 1 stated Resident 1 had informed her his previous room allowed him to look out the window at cars and people passing by and staff had been more interactive with him. FM 1 stated Resident 1 had become gloomy and staff in the new room had not understood him as well. FM 1 stated in his previous room he had been more encouraged and had enjoyed watching people and cars outside the window. FM 1 stated the view from the new room only allowed him to see other residents and did not offer the same stimulation. FM 1 stated she met with the Social Services Director (SSD) and Social Services Assistant (SSA) to request another room so Resident 1 could have a front^facing window again. FM 1 stated the SSD informed her someone else needed Resident 1's room so the (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other resident could be closer to the nursing station. FM 1 stated the SSD told her the facility was looking into another room for Resident 1 but could not promise when it would be available. FM 1 stated the room change occurred about three weeks prior and the facility should not have moved Resident 1 abruptly. FM 1 stated Resident 1 had been frustrated because staff had not listened to him and the facility moved him without informing him in advance. FM 1 stated Resident 1 was alert and able to make decisions for himself and stated she was the emergency contact.During a concurrent interview and record review on 6/18/2026 at 11:15 a.m., with Resident 1, Resident 1's Notice of Room Change was reviewed. Resident 1 stated he preferred his previous room because the view was better and nurses had been more attentive in that location. Resident 1 stated he did not want to look at the residents sitting on the patio and wanted to see outside toward the street, where cars and people were passing by, because it reminded him of home. Resident 1 stated, I do not want to look outside and see other residents like me. Resident 1 stated he was not given advance notice of the room change. Resident 1 stated staff came in and woke him up on 5/29/2026 between 8:30 a.m. and 9:30 a.m. and informed him he would be moved to another room. Resident 1 stated he felt disappointed but said okay. Resident 1 stated staff told him the move would occur after lunch but returned within an hour and began moving him. Resident 1 stated he did not receive a written notification. Resident 1 stated he wanted to speak with the social worker regarding the move, but the social worker was not available at the time. Resident 1 stated he felt disappointed of the room change but believed there was nothing he could do. Resident 1 stated he was not provided with a copy of the Notice of Room Change to sign and was not given the option to decline signing the form or to refuse the room change. Resident 1 reviewed the Notice of Room Change form in his medical record and stated he had never seen the form. [JH1.1][BS1.2]Resident 1 stated he did not authorize a verbal consent as the Notice of Room Change form indicated. Resident 1 stated he believed he did not have a choice in the room change. During an interview on 6/18/2026 at 1:13 p.m., with the SSD, the SSD stated she was responsible for notifying residents of room changes. The SSD stated staff were required to obtain consent before moving a resident to another room. The SSD stated Resident 1 had capacity to sign the Notice of Room Change. The SSD stated she should have provided Resident 1 with the Notice of Room Change to sign and should not have documented Resident 1 preferred to give verbal consent instead of a signature. The SSD stated she did not provide Resident 1 with the Notice of Room Change to sign and did not provide Resident 1 with a copy of the Notice of Room Change. The SSD stated Resident 1 should have signed the Notice of Room Change because Resident 1 had capacity to sign. The SSD stated not having Resident 1 sign the Notice of Room Change was an issue because Resident 1 was disputing the room change. The SSD stated she did not complete a progress note regarding Resident 1's room change. The SSD stated she did not document Resident 1 was provided the Notice of Room Change, was offered the opportunity to sign the Notice of Room Change, was informed of his right to refuse the room change or was provided a copy of the Notice of Room Change.During a concurrent interview and record review on 6/18/2026 at 1:41 p.m., with the Director of Nursing (DON), Resident 1's Notice of Room Change dated 5/29/2026, Nursing Progress Notes, and Social Services Notes were reviewed. The DON stated residents had the right to refuse a room change. The DON stated staff should ensure alert residents signed the room-change consent, so it was mutually understood the resident knew about, agreed to, and understood the room change. The DON stated if a resident had capacity to sign, the resident should sign the Notice of Room Change. The DON stated Resident 1 should have been provided with the Notice of Room Change to sign and should have been provided with a copy of the Notice of Room Change. The DON stated there was no documentation in the Nursing Progress Notes or Social Services Notes which indicated Resident 1 was provided with the Notice of Room Change to sign, was informed of his right to refuse the room change or was provided with a copy of the Notice of Room Change.During a review of the facility's policy and procedure titled, Room Change/Roommate Assignment, revised 1/2026, the P&P indicated resident preferences were taken into account when such changes were considered and residents had (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the right to refuse to move to another room in the facility unless necessary for health or safety reasons. The P&P indicated documentation of a room change was recorded in the resident's medical record. During a review of the facility's P&P, titled, Transfer, Room to Room, revised 1/2026, the P&P indicated staff were to orient the resident to the transfer in a form and manner the resident could understand and provide the resident with information about where the room was located, who the resident's new roommate would be, who would provide the resident's care, that the resident's family and visitors would be informed of the room change, and why the transfer was taking place. The P&P indicated, if possible, staff were to take the resident to see his or her new room before the actual move was made. The P&P indicated documentation recorded in the resident's medical record included the date and time the room transfer was made, the name and title of the individuals who assisted in the move, all assessment data obtained during the move, how the resident tolerated the move, and if the resident refused the move, the reason why and the intervention taken. The P&P indicated staff were to notify the supervisor if the resident refused the move.