

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 11/15/2022
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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331</p> <p>Based on interview and record review, the facility failed to provide supervision to ensure the resident, who had a history of elopement (leaving unnoticed without permission) and a diagnosis of dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) did not leave the facility out on pass (OOP) with two family members (FM 2 and FM 3) who were not listed as the resident's responsible [(RP) a person who may act alone without the other agent or join to make medical decisions; authorized to make all health care decisions) for one of one resident (Resident 1). The facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the facility's staff followed a physician's order for Resident 1 to go OOP with a responsible party. 2. Ensure the facility's staff verified and/or contacted Resident 1's listed responsible party RP 1 and RP 2 to verify if FM 2 and FM 3 were a part of the Resident 1's representatives and responsible parties. 3. Ensure the facility's staff adhere to its policy titled, Leave of Absence by ensuring Resident 1 was signed OOP by her responsible party or those persons who were designated by responsible party. <p>These failures resulted in Resident 1 not returning to the facility for two weeks, being displaced from the facility without receiving adequate care and treatment by FM 2 and FM 3, including not receiving daily significant medications for two weeks. On 10/22/2022, while out of the facility with FM 2 and FM 3, Resident 1 was admitted to the general acute hospital (GACH) due to urinary tract infection ([UTI] an infection in any part of the urinary system), excess agitation (exacerbation [worsen] of dementia), abnormal laboratory results, and needed placement. Resident 1 was admitted to the GACH for six days.</p> <p>Findings: (continued on next page)</p>

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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Admission Record (AR), dated 11/1/2022 indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), chronic diastolic heart failure (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly), hypothyroidism (the thyroid gland [a butterfly-shaped organ located in the base of the neck; releases hormones that control metabolism {the way the body uses energy}] does not make enough thyroid hormones to meet the body's needs) and anxiety disorder (involves persistent and excessive worry that interferes with daily activities). The AR indicated Resident 1's family members RP 1 and RP 2 were listed as the responsible parties.</p> <p>During a review of Resident 1's Advance Health Care Directive ([AHCD] legal documents used one's decisions about end-of-life care ahead of time), dated 7/2/2022, the AHCD indicated Resident 1's family members RP 1 and RP 2 were listed as Resident 1's responsible parties and had a durable power of attorney ([DPOA] an appointment of an agent if one becomes disabled or incapacitated - [no longer have the ability, due to illness or injury, to make decisions for oneself]) over Resident 1.</p> <p>During a review of Resident 1's Minimum Data Set (MDS), a standardized assessment and care-screening tool, dated 9/3/2022, the MDS indicated Resident 1 had clear speech but difficulty in communicating some words or finishing thoughts, but was usually understood. The MDS indicated Resident 1 required an extensive assistance with walking, dressing, and using the toilet.</p> <p>During a review of Resident 1's History and Physical (H/P), dated 9/7/2022, the H/P indicated Resident 1 had unspecified dementia with confusion, cognition (thought process) impairment and memory loss with behavior problems of wanting to leave the facility, which required frequent redirection and close monitoring. The H/P assessment indicated the plan was to keep Resident 1 in the memory unit (with doors locked to prevent residents from leaving the facility) of the facility due to safety concerns and the resident risk for elopement.</p> <p>During a review of Resident 1's Physician Progress Note (PPN), dated 9/20/2022 and untimed, the PPN indicated Resident 1 had dementia with an altered level of consciousness (a state of reduced alertness or inability to arouse due to low awareness of the environment), and encephalopathy (damage or disease of the brain that affects and alters the brain function or structure).</p> <p>During a review of Resident 1's physician's orders, dated 9/26/2022, the physician orders indicated Resident 1 was receiving Albuterol inhaler (used to prevent and treat wheezing [shrill, coarse whistling or rattling sound the breath makes when the airway is partially blocked] and shortness of breath caused by breathing problems) two puffs (act of inhaling [to breathe in]) as needed every 4 hours for shortness of breath, ordered on 8/23/2022, Aricept 5 milligram ([mg] unit of measurement) tablet (used to treat confusion [dementia]) at bedtime for dementia, ordered 8/25/2022, Aspirin 81 mg daily for prevention of cerebral vascular accident ([CVA/stroke occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain bursts) ordered 8/25/2022, Buspirone 5 mg tablet every day for agitation related to anxiety disorder, ordered 9/1/2022, Famotidine 20 mg (used to decrease the amount of acid in the stomach) twice a day, ordered on 8/31/2022, Lipitor 40 mg (used to treat high cholesterol; to lower the risk of stroke, heart attack), one tablet at bedtime for hyperlipidemia (used to treat high cholesterol [fats], and to lower the risk of stroke, heart attack), ordered on 8/25/2022, and Lasix 20 mg every day for edema (swelling, due to trapped fluid), ordered on 8/25/2022.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's physician order dated 9/26/2022, the physician's order indicated an order dated 8/25/2022 and timed at 8:08 p.m. that Resident 1 may go OOP with the responsible party, if not in conflict with treatment plan.</p> <p>During a review of the facility's Release of Responsibility for Leave of Absence (RORFLA) for Resident 1, dated 10/8/2022 and timed at 12:31 p.m., the RORFLA required a signature of the person accepting responsibility for Resident 1 to go OOP. However, the person who signed Resident 1 OOP was not listed as Resident 1's RP on Resident 1's AR face sheet.</p> <p>During a review of Resident 1's Nursing Progress Note (NPN), dated 10/8/2022 and timed at 4:47 p.m., the NPN indicated Resident 1 went OOP earlier on the morning shift (7 a.m., to 3 p.m.). At 4 p.m., the same day, the NPN indicated Resident 1's FM 2 and FM 3 came to the facility demanding Resident 1's medical records, stating they have a new Power of Attorney (POA) for Resident 1. The family member (FM 2) stated, I'm not bringing the resident (Resident 1) back to the facility. The NPN indicated the police were called and before the police arrived the family members (FM 2 and FM 3) left the facility. The NPN indicated Resident 1's listed RP 1 RP 2 were informed of the situation and RP 2 stated they were going to call the police to report the incident as a kidnapping (action of abducting someone and holding them captive).</p> <p>During a telephone interview on 11/14/2022 at 3:30 p.m., RP 2 stated FM 2 and FM 3, who took Resident 1 OOP on 10/8/2022, were other family members to Resident 1. RP 2 stated the facility failed to notify RP 1 and RP 2 of the other family members visiting and taking Resident 1 OOP. RP 2 stated FM 2 and 3 did not have permission to take Resident 1 out of the facility, but the facility allowed them to take the resident OOP. RP 2 stated FM 2 and 3 abducted Resident 1 on 10/8/2022 and took the resident somewhere and obtained another DPOA which indicated FM 2 and FM 3 were listed as Resident 1's responsible parties. RP 2 stated FM 2 and FM 3 returned to the facility the same day without the resident and informed the facility they now had DPOA. RP 2 stated FM 2 and FM 3 kept Resident 1 for two weeks and when they could no longer care for Resident 1, FM 2 and FM 3 took Resident 1 to the hospital.</p> <p>During a review of Resident 1's GACH discharge note, dated 10/29/2022, the discharge note indicated Resident 1 was admitted to the GACH on 10/22/2022 with a UTI, low levels of thyroid hormones, possibly due to not taking her medications for two weeks, increased aggressive behavior, including threats to leave and to kill herself. The GACH discharge note indicated Resident 1 was residing in a nursing home, and three weeks prior the resident's family members (FM 2 and FM 3), who states they now have the DPOA decided to take the resident out of the nursing home because they were unhappy with the care.</p> <p>During a review of the GACH's social worker (SW) note, dated 10/25/2022 and timed at 5:02 p.m., titled, 'Suspected Dependent Adult/Elder Abuse,' the note indicated the SW was consulted due to family concerns, as it was unclear who had DPOA of Resident 1. The note indicated FM 2 and FM 3 had a recent DPOA, dated 10/8/2022. The SW note indicated she spoke to Resident 1's RP 1 and was told he and RP 2 had DPOA of Resident 1 since 7/2/2022 and provided a verified copy of the DPOA. The SW note indicated RP 1 and RP 2 stated FM 2 and FM 3 took Resident 1 from the facility without permission and had a DPOA done that day (10/8/2022). Due to safety concerns, the SW's note indicated she contacted the facility and was informed FM 2 and FM 3 took Resident 1 OOP on 10/8/2022 and did not return the resident to the facility. The SW note indicated the facility called the police and filed a report for Resident 1's abduction (the act of taking someone away by force or cunning; kidnapping).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/17/2022 at 2:15 p.m., the Administrator (ADM) stated Resident 1's abduction was not recognized as a reportable event and so he did not report it to the Department. The ADM stated Resident 1 had a physician order to go OOP with RP 1 and RP 2. The ADM stated it was the first time an event of abduction has occurred in the facility. The ADM stated the resident's physician was notified and gave an order for the resident to be discharged against medical advice (AMA). The ADM stated the AMA documentation indicated Resident 1 acknowledging the discharge against medical advice and the risk and benefits were explained. The AMA documentation was not provided when requested from the ADM.</p> <p>During a telephone interview on 11/28/2022 at 3:05 p.m., with Resident 1's attending physician (Physician 1), Physician 1 stated the responsible party was the person listed on Resident 1's AR Face Sheet. Physician 1 stated the social worker should have investigated the family dynamics and informed him. Physician 1 stated he was not made aware Resident 1 was going OOP with a person other than a responsible person, as per his order. Physician 1 stated since the resident was not returned to the facility it was not AMA because Resident 1 was not present in the facility to explain the risk of AMA and/or sign acknowledging she (Resident 1) was informed.</p> <p>During a review of the facility's policy and procedure (P/P) titled, 'Leave of Absence' (LOA) dated 11/2012, the LOA policy indicated all residents leaving the premises must be signed out and signed from/to the facility and have clearance from resident's physician to go out on passes. Each resident leaving the premises must be signed out in the sign-out register-by the resident if he/she is his/her own responsible party; or responsible party/legal guardian; or those persons designated by responsible party or legal guardian.</p> <p>During a review of the facility's P/P titled, 'Physician's Orders, Accepting, Transcribing and Implementing,' with a revised date of 11/2012, the P/P indicated licensed nursing personnel will ensure that the physicians' telephone and verbal orders be recorded and implemented.</p> <p>During a review of the facility's P/P titled, 'Resident Supervision and Monitoring,' last revised in 4/2017, the P/P indicated residents were provided with intense supervision when they present with conditions that may place other residents and/or themselves at risk for harm.</p>		