STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055203	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Village Care Center	1428 S. Marengo Ave. Alhambra, CA 91803

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a psychiatrist (a medical doctor who diagnoses and treats mental, emotional, and behavioral disorders) /psychologist (a person who specializes in the study of mind and behavior) consult was provided timely for an acute change in condition as ordered for one of two sampled residents (Resident 1) in accordance with the Physician's order, care plan, and facility policy. This failure resulted in no psychiatric consultation (evaluation) for 25 days, with the potential for Resident 1 to experience a decline in mental and/or psychosocial (having to do with the mental, emotional, social, and spiritual) wellbeing and/or a lack of services/treatments to maintain or attain Resident 1's highest practicable mental and psychosocial wellbeing.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertensive heart disease (heart problems caused by long-term high blood pressure) with heart failure (a chronic condition in which the heart does not provide adequate blood flow to meet the body's needs), and difficulty in walking. During a review of Resident 1's Minimum Data Set (MDS -resident assessment tool), dated 10/31/2025, the MDS indicated Resident 1 had intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 1 was independent (resident completes the activity by themselves with no assistance from a helper) with eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. During a review of Resident 1's Order Summary Report, dated 11/25/2025, the Order Summary Report indicated for a psychiatrist/psychologist consult. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR -a communication tool used by healthcare workers when there is a change of condition among the residents) , dated 11/25/2025, the SBAR indicated Resident 1 with a behavioral change of verbal aggression towards a department of Public Health (DPH) surveyor and refusal of blood glucose fingerstick, with a doctor's recommendation from psychologist/psychiatrist consult. During a review of Resident 1's Episode of Profane Language care plan, dated 11/25/2025, the care plan indicated the intervention of psychiatrist/psychologist consult. During an interview on 12/22/2025 at 2:34 PM with Registered Nurse 1 (RN 1), RN 1 stated Resident 1 experienced a behavioral change of condition on 11/25/2025 and a psychiatrist/psychologist consult was ordered. During an interview on 12/22/2025 at 3:40 PM with Psychiatrist 1, Psychiatrist 1 stated he was the psychiatry consultant for the facility and was not made aware Resident 1 had a psychiatry consult ordered on 11/25/2025 for an acute behavior change. Psychiatrist 1 stated he was at the facility on 12/21/2025 conducting routine rounds on other residents and was then informed by facility staff for the first time to consult with Resident 1. Psychiatrist 1 stated, he completes an evaluation once informed by nursing staff anytime a resident needs to be evaluated. Psychiatrist 1 stated he conducts resident evaluations when there is an acute episode of behavioral changes to evaluate for necessary treatments including medications, and acute behavioral episodes can include aggressive behaviors, violent behaviors, or potential danger to self or others including staff which can result in Resident 1 not being able to be cared for in the facility. During an interview on 12/23/2025 at 8:20 AM with RN 2, RN 2 stated per facility protocol, when a psychiatrist/psychologist consult is ordered, nursing staff inform Psychiatrist 1 of the order the same day, and the psychiatrist or physician assistant (PA) will come to the facility the next day. RN 2 stated Resident 1 should have had a psych consult before 12/21/2025, unless he refused. RN 2 also stated nursing should have followed up to ensure Psychiatrist 1 was aware of the ordered consult and it was important that Resident 1 received the consult to evaluate if there is [new] problem because only Psychiatrist 1 has the expertise to evaluate. RN 2 stated if the evaluation is not done, appropriate modifications and or treatments cannot be provided to the resident. During an interview on 12/23/2025 at 9:17 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had a psychiatrist/psychologist consultation ordered two to three weeks ago and did not think Resident 1 had been seen yet. LVN 1 stated she was busy and did not follow up to see if the psych consult was endorsed or completed. During an interview on 12/23/2025 at 11:33 AM with LVN 2, LVN 2 stated per facility protocol, when a psychiatrist/psychologist consult is ordered, nursing is supposed to notify the psychiatrist in charge, and the psychiatrist will come to evaluate the resident. LVN 2 stated nursing staff should have endorsed the ordered consult each shift to ensure the consult is followed up and completed, and if Resident refused, documentation would be done regarding the refusal and doctor