STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055870	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunray Healthcare Center	3210 W Pico Blvd Los Angeles, CA 90019

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement the facility's policy and procedure (P&P) titled, Abuse, Neglect [s the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress], Exploitation (taking advantage of a resident for personal gain through the use of manipulation, intimidation, or threats) and Misappropriation Prevention Program, for one of three sampled residents (Resident 1) reviewed for abuse by failing to: -Ensure to provide one-on-one abuse training for Certified Nurse Assistant 3 (CNA3) prior to having direct-care responsibilities for residents following a three-day suspension after an allegation of abuse. This failure had the potential to place Resident 1 at risk for abuse, neglect, and feeling intimidated. Findings: During a review of Resident 1's admission Record dated 1/15/2026, the admission Record indicated the facility admitted Resident 1 on 10/23/2025 with diagnoses including diverticulitis (infection of small pouches of the intestines causing sudden stomach pain), muscle weakness, dysphagia (difficulty swallowing), depression (persistent sadness or loss of pleasure), and colostomy status (a surgical opening in the belly that diverts stool from the colon into an external removable bag). During a review of Resident 1's History and Physical (H&P) dated 10/23/2025, the H&P documented that Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool) dated10/23/2025, the MDS documented that Resident 1's cognitive skills (relating to the process of having knowledge and understanding through thought experience). The MDS documented that Resident 1 had the capacity to understand and make decisions on her own. The MDS documented that Resident 1 required moderate to maximum assistance from facility staff for activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting). During a review of Resident 1's Progress Notes dated 1/1/2026 at 2 PM, the Progress Notes documented that Resident 1 reported an allegation of abuse on 1/1/2026 at 8:40 AM. The Progress Notes documented that Resident 1 alleged that a CNA (CNA3) from the 11PM to 7AM shift showed arm gestures with two closed fists. The Progress Notes documented that Resident 1 alleged she felt afraid towards the CNA3. The Progress Notes documented that Resident 1 alleged that CNA3 aggressively woke Resident 1 up. The Progress Notes documented that Resident 1 alleged that CNA3 threw two towels on her chest and another towel on her colostomy site. The Progress Notes documented that Resident 1 alleged CNA 3 turned and pulled her while providing incontinence care and told her that if she (Resident1) would speak up about what happened she (Resident 1) would be hit while gesturing with her arms and two closed fists. The Progress Notes documented that the facility initiated an Investigation, and suspended CNA3 while the investigation was ongoing. During a review of the facility's 5-Day Conclusion of Facility Reported Incident dated 1/12/2026, the 5-day Conclusion of Facility Reported incident documented that CNA 3 was suspended pending investigation of the alleged abuse. During a record review of the Time sheet dated 1/15/2026. The Time sheet card indicated that CNA 3 went to the facility to work on 1/4/2026. During a (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review of the Facility's Inservice Record Sheet conducted by Quality Assurance Nurse (QAN) to CNA 3 dated 1/5/2026 (after CNA3 provided resident care) summary of presentation documented to ensure all resident received a safe, respectful and dignified care at all times. During a concurrent interview on 1/15/2026 at 11:15 AM, with the QAN and the Director of Staff Development (DSD), the QAN stated CNA3 went to work on 1/4/2026 at 11 PM and CNA3's shift ended at 7 AM. The QAN stated that he (QAN) did not provide an in-service to CNA3 prior to CNA3 returning to do resident care. The DSD stated she (DSD) was responsible for providing a one-one in-service prior for CNA 3 to provide care to other residents in the facility. The DSD stated it was important to make sure CNA 3 had understood the abuse allegations that Resident 1 reported to the facility and knew how to prevent it from happening again. The DSD stated that she (DSD) did not work during week of 1/1/2026. During a concurrent interview on 1/15/2026 AT 1:30 PM with the Administrator (ADM), the ADM stated CNA3 was suspended pending investigation. The ADM stated that he (ADM) called CNA3 to report to work on 1/4/2026 as the investigation was concluded on 1/4/2026. The ADM confirmed that in-service was not done for CNA3 prior to start of her shift. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, under Resident Rights Guidelines for All Nursing Procedures, the P&P indicated to provide general guidelines for resident rights while caring for the resident. The P &P indicated Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including: Preventing, recognizing and reporting resident abuse; Resident dignity and respect; Resident notification of rights, services and health/medical condition; Resident's freedom of choice. The P& P indicated Implement measures to address factors that may lead to abusive situations, to adequately prepare staff for caregiving responsibilities, provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation and Instruct staff regarding appropriate ways to address interpersonal conflicts; The P &P also indicated help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. Investigate and report any allegations within timeframes required by federal requirements.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1), reviewed for behavioral health services who had a diagnosis of depression (a mood disorder that causes persistent feeling of sadness and loss of interest) received appropriate mental health services and support. On 1/1/26, R1 alleged that CNA3 abused her, and on 1/5/26, R1's physician noted that R1 had increased nighttime anxiety and was afraid to fall asleep. The facility failed to identify R1's increased anxiety and failed to implement care-planned interventions in response to R1's change in behavioral health symptoms. 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 including hypertension (HTN-high blood pressure), hyperlipidemia (abnormally high levels of fats in the blood), depression, presence of colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 1's Order Summary dated 10/23/2025, the Order Summary indicated Resident 1 to receive a psychology (the study of mind and behavior) consult and treatment as needed. During a review of Resident 1's History and Physical (H&P) dated 10/23/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of the Minimum Data Set (MDS - resident assessment tool) dated 10/28/2025, indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated Resident 1 required moderate to maximum assistance from the staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Progress Notes dated 1/1/2026 at 2 PM, the Progress Notes indicated Resident 1 reported an allegation of abuse on 1/1/2026 at 8:40 AM. The Progress Notes indicated Resident 1 alleged that a CNA (CNA3) from the 11PM to 7AM shift showed arm gestures with two closed fists. The Progress Notes indicated Resident 1 alleged Resident 1 felt afraid towards the CNA(CNA3). The Progress Notes indicated Resident 1 alleged the CNA (CNA3) aggressively woke Resident 1 up. The Progress Notes indicated Resident 1 alleged the CNA (CNA3) threw two towels on her chest and another towel on her colostomy site. The Progress Notes Resident 1 alleged CNA 3 turned and pulled Resident 1 while changing Resident 1 and told Resident 1 if she (Resident1) would speak up about what happened she (Resident 1) would be hit with arm gestures with two closed fists. The Progress Notes indicated the facility initiated an Investigation, CNA3 suspended while the investigation was ongoing. During a review of Resident 1's Care Plan Report dated 1/2/2026, the Care Plan Report indicated Resident 1 had a psychosocial well-being problem due to a language barrier. The Care Plan Report indicated interventions with consultations with pastoral care, social services, and psych services. During a review of progress note titled MD/NP/PA Progress Note dated 1/5/2026, Resident 1's Primary Medical Doctor (PMD) wrote, resident [Resident 1] had an interaction with a staff member 2 [two] days ago during which she [Resident 1] felt threatened that the CNA [CNA 3] will hurt her. No physical contact occurred. Since then, resident [Resident 1] is afraid to fall asleep. CNA [CNA 3] was suspended. According to resident [Resident 1's] husband, resident [Resident 1] has a chronic anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities) and this incident caused a flare of nocturnal anxiety. During a review of Progress Notes dated 1/8/2026 timed 10:34 PM, the Progress Notes indicated Resident 1 stated she (Resident 1) did not feel safe. During a concurrent observation and (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 1/15/2026 at 8:20 AM in Resident 1's room Resident 1 grimaced (frowned), shifted side to side, gagged, and stated she (Resident 1) felt nauseous (a feeling of sickness with an urge to vomit). Resident 1 stated she (Resident 1) preferred not to discuss Resident 1's allegation of abuse with CNA3. During a concurrent interview and record review on 1/15/2026 at 10:33 AM with Social Service Supervisor (SW) Resident 1's general medical records were reviewed. The SW stated his responsibilities included assessing residents' social needs (in general), arranging referrals, and supporting their mental, psychosocial, and emotional wellness in the facility. The SW stated trauma assessments were done on admission, quarterly, and at change of condition. The SW stated Resident 1 made remarks about certain people of different ethnicities being loud, harmful, and unfriendly. The SW stated Resident 1 stated not being comfortable with certain staff of a different ethnicity. The SW stated Resident 1 could possibly have a past trauma causing her reaction. The SW stated there was no behavioral assessment done for Resident 1's change of condition (COC) on 1/1/2026. The SW stated the importance of assessment and reassessment in evaluating and adjusting the resident's care plan (in general). The SW indicated that interdisciplinary team (IDT- a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) were responsible for updating the resident care plan. The SW stated that a behavior change required a COC. The SW stated the care plan interventions for Resident 1 included consultations with pastoral care, social services, and psych services. The SW stated there were no psychologist's progress notes for Resident 1. During an interview and record review on 1/15/2026 at 11:44 AM with the Minimum Data Set Coordinator (MDS), Resident 1's assessment records were reviewed. The MDS stated there were no behavioral assessments done for Resident 1 for 1/1/2026. During an interview on 1/15/2026 at 9:30 AM, with the Quality Assurance Nurse (QAN), the QAN stated steps following an abuse allegation included to reassure the resident, notify family/doctor, arrange for a psych evaluation, consult social services, initiate a COC for 72-hour emotional distress monitoring, update the care plan, and meet with the IDT (in general). The QAN stated that if after 72 hours the resident would still feel unsafe the facility needed to have a new intervention. During a concurrent interview and record review of the nursing notes with Director of Nursing (DON) on 1/15/26 at 11:44 AM, the DON stated she (DON) did not know that Resident stated she (Resident1) did not feel safe on 1/8/2026. The DON stated Registered Nurse 2 (RN 2) needed to notify the doctor that Resident 1 stated she (Resident 1) did not feel safe. During a review of the facility's policy and procedure (P&P) revised on 03/2019 titled Behavioral Assessment, Intervention and Monitoring, the P&P indicated that Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to receive the services and/or items included in the plan of care. The P & P indicated the nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including: a. onset, duration. intensity and frequency of behavioral symptoms; b. any recent precipitating or relevant factors or environmental triggers (e.g medication changes, infection, recent transfer from hospital); and c. appearance and alertness of the resident and related observations. The P & P also indicated the interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition, including: physical or medical changes, emotional, psychiatric and/or psychological stressors, functional, social or environmental factors. The P & P indicated Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents distress or loss of abilities. The IDT will monitor the progress of individuals with impaired cognition and behavior until stable. New or emergent symptoms will be documented and reported. During a review of the facility's policy and procedure (P&P) revised on 08/2022 titled Trauma Informed Care and Culturally Competent Care, the P&P indicated that resident assessments involve evaluating symptoms' presence, their link to trauma, and identifying triggers. The P&P also indicated in the Resident Care Planning which included Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. Identify and decrease exposure to triggers that may re-traumatize the resident. Recognize the relationship between past trauma and current health concerns. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values. During a review of facility's P&P revised 03/2022 titled Care Plans, Comprehensive Person-Centered, the P&P indicated that Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process; d. request revisions to the plan of care: g. receive the services and/or items included in the plan of care; and h. see the care plan and sign it after significant changes are made. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition: b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.