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	05/21/2026

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 observation, interview, and record review, the facility failed to implement its Abuse Prevention Program, Abuse and Neglect, and Abuse Investigation and Reporting policies and procedures (P&P) for one of three sampled residents (Resident 1) reviewed for resident abuse by failing to: - Ensure Housekeeper 1 did not physically force Resident 1's right hand to open, causing Resident 1 to scream in pain on 5/9/2026 at 4 PM. -Ensure Registered Nurse 1 (RN1) identified and reported Resident 1's Family 1's allegation of physical abuse to the facility's Administrator (ADM), the Director of Nursing (DON), the Ombudsman (an official appointed to investigate individuals' complaints against maladministration), local police, and to the California Department of Health (CDPH) on 5/9/2026 at 4 PM. -Ensure Registered Nurse 1 conducted private interviews with Resident 1 and Family 1 separately and in a private location on 5/9/2026 and did not allow Housekeeper 1 to confront Resident 1 and Family 1. -Ensure Housekeeper 1 received abuse prevention training as required. These failures caused Resident 1 to scream in pain and had the potential to increase Resident 1's risk for potential abuse.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility admitted the resident on 8/1/2023, with diagnoses that included dementia (a progressive state of decline in mental abilities), cerebral infarction (a medical emergency caused by disrupted blood flow to the brain), and transient ischemic attack (a mini-stroke, occurs when blood flow to the brain is temporarily blocked). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/23/2026, the MDS documented that R1 required maximum assistance (helper does more than half the effort) from staff to complete activities of daily living (ADLs, activities a person performs daily such as bathing, dressing, and toileting). The MDS documented thatR1's cognition was severely impaired (significant difficulty with memory, orientation, and recalling information). During a review of Resident 1's Care Plan Report, revised on 4/23/2026, the Care Plan Report documented that R1 was at risk for decline in range of motion (ROM, how far and in what direction you can move a joint or muscle) due to upper and lower extremity weakness. The Care Plan Report documented that nursing interventions included that staff were to monitor for signs of pain or stiffness and alert nurses of any changes. During a review of Resident 1's Progress Notes dated 5/13/2026, the Progress Notes documented that Resident 1 stated he (Resident 1) lost functioning in his right hand after a stroke. During a review of Resident 1's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 5/19/2026, the OT Evaluation and Plan of Treatment documented that Resident 1 had decreased ROM in the right hand. During a review of Resident 1's Post-Event Review dated 5/20/2026, the Post-Event Review documented that Resident 1's family alleged that a housekeeper [Housekeeper1] touched the resident's hand on 5/9/2026 at 4 PM. During a review of Family 1's email sent to the facility titled, Urgent Formal Complaint - Abuse, Neglect, and Safety Concerns Regarding [Resident 1], dated 5/12/2026, the email indicated that on 5/9/2026 at 4PM Housekeeper 1 Without our permission and without any medical authorization, she [Housekeeper 1] forcefully grabbed and attempted to pry open his hand [Resident 1]. The email indicated Resident 1 Immediately screamed in pain and repeatedly told her [Housekeeper 1] he [Resident 1] could not move or open his hand himself. She [Housekeeper 1] continued despite his [Resident 1] visible pain and distress. The email indicated Witnessing a staff member [Housekeeper 1] physically force (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
	055870	A. Building B. Wing	05/21/2026

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	movement on a stroke patient [Resident 1] causing him [Resident 1] pain was deeply alarming and traumatic for our family. We immediately reported the incident to the manager or supervisor [RN1] on duty. During an observation on 5/21/2026 at 9:38 AM in front of Resident 1's room, Resident 1 had a splint (a firm material used for supporting and immobilizing an arm or leg) on his right arm. During a phone interview on 5/21/2026 at 10:24 AM with Housekeeper 1, Housekeeper 1 denied physically touching Resident 1 and stated she massaged her own hand to demonstrate to Family 1 how to massage Resident 1's right hand. Housekeeper 1 stated she remained at the facility to finish her shift on 5/9/2026 after the incident. Housekeeper 1 stated that her most recent abuse training was over a year ago. During a phone interview on 5/21/2026 at 11:30 AM with Family 1, Family 1 stated that on 5/9/2026 at 4PM while at the outside smoking area, Housekeeper 1 grabbed Resident 1's hands without permission which caused Resident 1 to scream in pain. Family 1 stated she immediately reported what happened to Registered Nurse1 (RN 1). Family 1 stated RN 1, Housekeeper 1, Certified Nursing Assistant 1(CNA 1) went to Resident 1's room after the incident to discuss with Family 1 and Resident 1 what happened. During a phone interview on 5/21/2026 at 12 PM with Housekeeper 1, Housekeeper 1 stated that she (Housekeeper 1) went to Resident 1's room after the incident on 5/9/2026 to confront Family 1 about the accusation. During a phone interview on 5/21/2026 at 12:39 PM with CNA 1, CNA 1 stated herself, RN 1, Housekeeper 1, Family 1, and Resident 1 were in Resident 1's room to discuss the incident. CNA 1 stated that she provided Spanish translation. During a concurrent interview and record review on 5/21/2026 at 1:16 PM with the Director of Staff Development (DSD), Housekeeper 1's employee file was reviewed. The employee file indicated Housekeeper 1's mandatory abuse prevention in-service training was past overdue since 4/30/2026. The DSD stated staff should complete in-service trainings to learn how to provide optimal care for residents. During a concurrent interview and record review on 5/21/2026 at 1:41 PM with the Maintenance Supervisor (MS) 1, Housekeeper 1's 5/2026 timesheet was reviewed. The timesheet documented that Housekeeper 1 worked full shifts on 5/9/2026 and 5/10/2026. MS 1 stated Housekeeper 1 notified him of the incident on 5/9/2026. MS 1 stated Housekeeper 1 continued to work after the incident was reported to RN 1. MS 1 stated he did not follow up with RN 1 and was not aware of an abuse allegation until 5/12/2026. During a phone interview with RN 1 on 5/21/2026 at 2:08 PM, RN 1 stated that Housekeeper 1 was not sent home after Family 1's complaint of Housekeeper 1 inappropriately touching Resident 1's hand because Family 1 did not explicitly verbalize that abuse had occurred. RN 1 stated when there was suspected staff-to-resident abuse, staff could not stay to finish his/her shift. RN 1 stated residents could feel unsafe and further abuse could be committed. RN1 stated she (RN1) did not report the incident to the ADM and or DON. RN1 stated she (RN1) did not document the incident in Resident 1's medical records. RN1 stated Resident 1's Family 1 stated they did not appreciate Housekeeper 1 touching Resident 1 and giving them medical advice. RN1 stated she (RN1) did not think the incident was considered abuse. During an interview with the DON on 5/21/2026 at 2:42 PM, the DON stated that forcibly pulling a resident's extremity (in general), causing the resident to scream was considered physical abuse. The DON stated that when there was suspected staff-to-resident abuse, staff must immediately clock out to prevent retaliation (revenge), otherwise staff could go back to intimidate the residents. The DON stated interviews between the victim and alleged abuser should have been conducted separately. The DON stated that Housekeeper 1 was on extended leave and recently came back. The DON stated Housekeeper 1 should have completed abuse prevention in-service training after returning from leave, to ensure competency. During an interview with the Administrator (ADM) on 5/21/2026 at 3:26 PM, the ADM stated Housekeeper 1 was not sent home because there was no official reported allegation of abuse on 5/9/2026, when the incident happened. The ADM stated he (ADM) was not aware that Housekeeper 1 went to confront Resident 1 and Family 1 after the incident. During a review of the facility's P&P titled, Abuse Prevention Program, revised August 2025, the P&P documented that the facility required staff training/orientation programs which would include topics such as abuse (continued on next page)

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	05/21/2026

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	prevention, identification, and reporting of abuse. The P&P documented that the facility would protect residents during abuse investigations. During a review of the facility's P&P titled, Abuse & Neglect - Clinical Protocol, revised August 2025, the P&P documented that facility staff would help identify risk factors for abuse within the facility; for example, issues related to staff knowledge and skill. During a review of the facility's P&P titled, Abuse Investigation and Reporting, revised August 2025, the P&P documented that Each interview with be conducted separately and in a private location.