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	04/19/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure safe food storage practices in the kitchen when: 1.One bottle of thickened coffee was stored in the reach in fridge with an open date of 2/27/2026, exceeding storage period indicated in the manufacturer's instructions. 2.Bulk food (sugar) was stored inside trash bags that were not food grade (specialized bags designed for the safe storage, transportation, and packaging of food items intended for human consumption). These failures had the potential to result in harmful bacteria growth and cross contamination of food (transfer of harmful bacteria and chemicals from one place to another) that could lead to food borne illness in 67 of 75 residents (unidentified) who received food from the facility.Findings: During an observation in the facility's kitchen on 4/18/2026 at 9:15AM, an open bottle of thickened coffee with receive date of 3/20/2025 and open date of 2/27/2026 was observed stored in the reach in refrigerator (an upright, commercial-grade cooling unit designed for easy access to ingredients, featuring front doors that allow staff to reach in for items rather than entering the unit.) During a concurrent observation of the reach in refrigerator and interview with the dietary supervisor (DS) on 4/18/2026 at 9:15AM, the DS stated the thickened coffee was for residents who were on thickened liquids (beverages modified with powders or gels to increase viscosity, designed for individuals with dysphagia (swallowing difficulties) to reduce aspiration risk. By slowing the liquid's flow, these drinks allow more time for throat muscles to control swallowing.) The storage instructions on the bottle written on the manufacturer's instructions were reviewed by the DS, the instructions indicated the thickened coffee had to be refrigerated after opening and used within 14 days of opening. The DS stated that the thickened coffee should have been discarded because it had been in the refrigerator for more than 14 days. The DS said serving the thickened coffee could have been bad. The DS stated kitchen staff had not served the thickened coffee lately. The DS stated serving the thickened coffee after 14 days from opening had potential to make residents sick. The DS was then observed removing the bottle of thickened coffee from the refrigerator to discard. During a review of facility's policy and procedures (P&P) titled, Food receiving and Storage revised 11/2023, the P&P indicated Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen or discarded. 2. During an observation in the facility's kitchen on 4/18/2026 at 9:40AM, bulk food (sugar) was observed stored in large bins that were lined with plastic bags (trash bags). During a concurrent observation in the facility kitchen and interview with the DS on 4/18/2026 at 9:40AM, the DS stated the plastic liners inside the bins were regular trash bags and were not food grade. The DS stated the facility had food grade liners, but kitchen staff used trash bags. The DS stated plastic trash bags were not good for food storage. During a follow up interview with the DS on 4/18/2026 at 4 PM, the DS stated plastic trash bags had chemicals and could contaminate the food. The DS stated staff should not have used plastic trash bags. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Characteristics code 4-102.11, the code indicated, The safety and quality of food can be adversely affected through single service and single use articles that are not constructed of acceptable materials. The migration of components of those materials to food they contact could result in chemical contamination and illness to the consumer. In addition, the use of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unacceptable materials could adversely affect the quality of the food because of odors, tastes, and colors transferred to the food.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to protect the privacy and dignity of one of two sampled residents (Resident 90) reviewed for urinary catheter (a soft hollow tube which is passed into the bladder to drain urine, for persons who cannot empty their bladder in the usual way) by failing to ensure to cover the urinary catheter drainage bag as indicated in the facility's policy and procedure (P&P) titled Dignity. This failure had the potential to affect Resident 90's sense of self-worth and self-esteem.Findings: During a review of Resident 90's admission Record, the admission Record indicated the facility originally admitted Resident 90 on 2/7/2020 and readmitted the resident on 4/13/2026 with diagnoses including hydronephrosis with renal and ureteral calculous obstruction (when kidney stones are causing a blockage in the tube draining the kidney, causing the kidney to swell with trapped urine), encounter for surgical aftercare following surgery on the genitourinary system (postoperative care on keeping the urinary system clean, preventing infection, and reducing pressure on the healing area), and agoraphobia (an anxiety disorder characterized by an intense fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs). During a review of Resident 90's Minimum Data Set (MDS - a resident assessment tool) dated 2/16/2026, the MDS indicated the resident required extensive assistance to total dependence from staff for activities of daily living (ADL- bed mobility, transfer, dressing, toilet use and personal hygiene). During a facility tour observation on 4/18/2026 at 9:26 AM, Resident 90's urinary catheter drainage bag was observed hanging on the side of the bed, not covered and urine was visible from the catheter drainage bag. During a concurrent observation and interview on 4/19/2026 at 12:01 PM with Treatment Nurse 1 (TN 1) inside Resident 90's room, TN 1 stated Resident 90's urinary catheter drainage bag was not covered with a privacy bag. TN 1 stated that the urinary catheter bag needed to be covered with a privacy bag. During an interview on 4/19/2026 at 4:57 PM with the Director of Nursing (DON), the DON stated the urinary catheters bags (in general) had to be covered with privacy bags for residents' (in general) privacy and dignity. During a review of facility's P&P titled Dignity, with a reviewed date of 8/2025, the P&P indicated that, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being. Staff are expected to promote dignity and assist residents; for example: helping the resident to keep urinary catheter bags covered.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to protect the personal belongings for one of one sampled residents (Resident 90) reviewed for personal property by failing to create an inventory list of Resident 90's belongings upon admission and readmission as per the facility's policy and procedure (P&P) titled, Personal Property dated 8/2025.This failure resulted in Resident 90's missing personal belongings.Findings: During a review of Resident 90's admission Record, the admission Record indicated the facility originally admitted Resident 90 on 2/7/2020 and readmitted the resident on 4/13/2026, 3/9/2026, 2/9/2026, and on 3/3/2025 with diagnoses including hydronephrosis with renal and ureteral calculous obstruction (when kidney stones are causing a blockage in the tube draining the kidney, causing the kidney to swell with trapped urine), respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide) and agoraphobia (an anxiety disorder characterized by an intense fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs). During a review of Resident 90's Resident's Clothing and Possessions (RCP) dated 3/3/2025, the RCP indicated staff documented, no belongings. During a review of Resident 90's Resident's Clothing and Possessions (RCP) dated 7/18/2025, the RCP indicated one gray + white stuffed animal dog, one blue stuffed bird with voice, one pink doll, one blue bear doll. During a review of Resident 90's Resident's Clothing and Possessions (RCP) dated 2/1/2026, the RCP indicated staff documented, None. During a review of Resident 90's Resident's Clothing and Possessions (RCP) dated 2/10/2026, the RCP indicated staff documented, Belongings at the facility. During a review of Resident 90's Minimum Data Set (MDS - a resident assessment tool) dated 2/16/2026, the MDS indicated Resident 90's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) were severely impaired for daily decision-making and required extensive assistance to total dependence from staff for activities of daily living (ADL- bed mobility, transfer, dressing, toilet use and personal hygiene). During a review of Resident 90's Resident's Clothing and Possessions (RCP) dated 3/9/2026, the RCP indicated staff documented, Resident belongings are here in the facility, see old inventory. During a review of Resident 90's Resident's Clothing and Possessions (RCP) dated 4/13/2026, the RCP indicated staff documented, please see previous inventory, all belongings are in the facility. During an interview on 4/18/2026 at 9:26 AM with Resident 90, Resident 90 stated, where is my bag? I want my bag. Resident 90 was unable to explain what the bag was and kept repeating herself asking for the bag. During a concurrent observation and interview on 4/19/2026 at 9:31 AM with Certified Nursing Assistant 6 (CNA 6) inside Resident 90's room Resident 90's closet and drawer were observed. CNA 6 stated there were no clothes and/or bags inside Resident 90's closet and drawer. CNA 6 stated that Resident 90 was moved from another room (unidentified) after hospitalization (unidentified date). During an interview on 4/19/2026 at 4:36 PM with the Social Services Director (SSD), the SSD stated Resident 90 had been recently hospitalized and was moved from another room. The SSD stated he (SSD) did not have Resident 90's personal belongings being kept at his (SSDs) office. The SSD stated during readmission, facility staff (in general) were to complete an inventory of resident's (in general) personal belongings. During a concurrent interview and record review 4/19/2026 at 4:49 PM with the Director of Nursing (DON), Resident 90's inventory lists dated 3/3/2025, 7/18/2025, 2/1/2026, 2/10/2026, 3/9/2026, and 4/13/2026 were reviewed. The DON stated Resident 90's personal belongings were not properly inventoried during admissions and readmissions because the inventory lists did not include personal belongings in detailed report. The DON stated the CNAs (in general) had to go through the residents' (in general) personal belongings and report to the licensed nurses (in general). The DON stated it was not appropriate to just document see previous inventory and the form should have been filled out completely. During a review of facility's P&P, titled Personal Property, reviewed on 8/2025, the P&P indicated that, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents are permitted to retain and use personal possessions. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary.The facility promptly investigates and complaints of misappropriation or mistreatment of resident property.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to accurately code the Minimum Data Set (MDS, a resident assessment tool) for one of two sampled residents (Resident 8) reviewed for antibiotics (medication that help stop infection caused by bacteria) by failing to: -Ensure to code Resident 6's use of antibiotics and diagnosis of cellulitis (serious bacterial infection of the deeper skin layers, causing painful, red, swollen, and hot legs or feet) of the left and right lower limbs (legs) on the MDS dated [DATE]. This failure had potential to negatively affect the provision of necessary care and services for Residents 8. Findings:During a review of Resident 8's admission Record, the admission Record indicated the facility admitted Resident 8 on 1/14/2026 with diagnosis including cellulitis of left and right lower limbs, and type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Order Summary Report dated 1/15/2026, the Order Summary Report indicated for Resident 8 to receive Vancomycin solution (antibiotic used to treat severe bacterial infections that do not respond to common antibiotics) 750 milligram/150 millimeter (mg/ml - unit of measurement) - use 150 ml intravenously (IV - means delivering medication, fluids, or blood directly into a person's vein) every 12 hours for right and left foot cellulitis During a review of Resident 8's Order Summary Report dated 1/15/2026, the Order Summary Report indicated for Resident 8 to receive piperacillin tazobactam solution (a powerful, broad-spectrum intravenous (IV) antibiotic used in hospitals to treat serious bacterial infections) 3.0375 gram (gm - unit of measurement) - use 3.375 gram intravenously two times a day for right and left foot cellulitis. During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 8 required assistance from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS for skin conditions indicated Resident 8 did not have any foot skin problems such as cellulitis. The MDS indicated Resident 8 was not on any antibiotic. During a concurrent observation and interview on 4/18/2026 at 10:30 AM with Resident 8, Resident 8 was observed with swollen skin and with redness on the skin on both lower limbs. Resident 8 was observed with an open wound on the left foot. Resident 8 stated he (Resident 8) had a wound on both of his legs. Resident 8 stated his left leg was swollen and tender and his left foot had an open wound. During an interview on 4/19/2026 at 11:47 AM with Treatment Nurse1 (TN 1), TN 1 stated Resident 8 had multiple skin conditions on both lower legs and foot and Resident 8 was being seen by a wound care specialist. During a concurrent interview and record review 4/19/2026 at 3:51 PM with the Minimum Data Set Nurse (MDSN), MDSN reviewed Resident 8's MDS assessment dated [DATE]. The MDSN stated Resident 8's MDSN for foot problem was coded as None and antibiotic medications coded as 0. The MDSN stated that Resident 8's diagnosis of cellulitis on both lower limbs and IV antibiotic medications were not coded. The MDSN stated that the MDS was coded incorrectly. The MDSN stated Resident 8's diagnosis of cellulitis and antibiotic medication should have been coded as yes upon assessment. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Assessments, reviewed on 8/2025, the P&P indicated, Comprehensive MDS assessments are conducted to assist in developing person-centered care plans. The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument specified by [Centers for Medicare & Medicaid Services, a federal agency that administers major U.S. healthcare programs] CMS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review the facility failed to develop a care plan for range of motion (ROM, the full movement potential of a joint) for one of six sampled residents (Resident 2) reviewed for limited ROM. This failure placed Resident 2 at risk for functional decline and had the potential to affect Resident 2's care and services received. Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 to the facility on 6/9/2023 with diagnoses including; thrombocytopenia (blood clotting deficiency), alcoholic cirrhosis of the liver (severe liver injury [scarring] and the final stage of alcohol associated liver disease), dysphagia (difficulty swallowing), epilepsy (chronic neurological disorder caused by abnormal electrical activity in the brain, characterized by recurrent seizures), hypertension (HTN, high blood pressure), and vascular dementia (brain dysfunction decline in thinking, memory, and behavior caused by conditions that damage blood vessels in the brain, reducing or blocking blood flow and oxygen). During a review of Resident 2's Order Summary Report dated 12/23/2025, the Order Summary Report indicated Resident 2 had an order for Restorative Nursing Assistant (RNA-nursing aide program that helps residents maintain their function and joint mobility) program daily three times a week for active range of motion (AROM - movement of joint by individual's own power unassisted) and passive range of motion (PROM - assisted movement of joint by person or machine) to bilateral (both sides) lower extremities (legs). During a review of the Minimum Data Set (MDS - resident assessment tool) dated 4/2/2026 indicated Resident 2 had moderate cognitive impairment (ability to think, reason, learn, and remember). The MDS indicated Resident 2 required supervision or touching assistance for eating and required partial/moderate assistance to being totally dependent on staff for other activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and bed mobility. During a concurrent interview and record review on 4/19/2026 at 6:28 PM with the Minimum Data Set Nurse (MDSN) Resident 2's care plans were reviewed. The MDSN stated there was no care plan for the ROM treatments and stated the process was to highlight the orders for the residents (in general) and to develop the care plan. The MDSN stated the ROM care plan for Resident 2 was not developed. During a review of the facility's Policy and Procedures (P&P) titled Care Plans, Comprehensive Person-Centered with a review date of 8/28/2025, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility staff failed to ensure one of two sampled residents (Resident 6) reviewed for activities of daily living (ADL's- activities related to personal care, including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) and was dependent on staff (helper does all of the effort) received care in accordance with the residents' plan of care by failing to:-Ensure the nursing staff (in general) assisted Resident 6 with meals on 4/19/2026 at 8:12 AM. This failure had the potential for Resident 6's increased the risk of inadequate nutrition and aspiration due to dysphagia (difficulty swallowing). Findings:During a review of Resident 6's admission Record, the admission Record indicated the facility admitted Resident 6 on 10/4/2024 and readmitted the resident on 1/24/2026 with a diagnoses including seizures (uncontrollable electrical activity in the brain that disrupts normal function), other encephalopathy (permanent brain damage that causes severe confusion and forgetfulness), type two diabetes (a long-term condition in which the body has trouble controlling blood sugar), acute pancreatitis (inflammation of the pancreas [a gland behind the stomach] that aids digestion and blood sugar control). During a review of Resident 6's History and Physical (H&P) dated 1/26/2026, the H&P indicated Resident 6 had a history of renal failure (kidneys can no longer adequately filter waste, toxins, and excess fluid from the blood), altered metal status (change in a person's normal mental state or level of awareness), and did not have the capacity to make medical decisions. During a review of Resident 6's Minimum Data Set (MDS- a resident assessment tool) dated 3/9/2026, the MDS indicated Resident 6 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) to make decisions on selfcare activities. The MDS indicated Resident 6 was dependent on staff for toileting hygiene, oral hygiene, transferring from bed to chair/chair to bed, shower/bath, personal hygiene, eating, sitting to lying, and sitting to stand. During a review of Resident 6's Order Summary Report dated 4/19/2026, the Order Summary indicated May participate in activities not in conflict with treatment plan. During a review of Resident 6's Care Plan Report dated 1/19/2026, the Care Plan Report indicated Resident 6 was at risk for aspiration (is when something enters the airway or lungs by accident) related to dysphagia (difficulty swallowing), the Care Plan Report indicated nursing staff was to assist Resident 6 with meals as needed and encourage the resident to eat slowly and take small bites of food. During an observation on 4/19/2026 at 8:12 AM inside Resident 6's room, Resident 6 was observed lying in bed, talking to self, not responding to verbal cue, breakfast tray on bedside table. Resident 6 was unable to feed himself, and there were no staff assisting the resident. During an interview on 4/19/2026 at 8:30 AM with Certified Nursing Assistant 5 (CNA 5), CNA 5 stated Resident 6 was dependent on staff for feeding. CNA 5 had not fed Resident 6 yet and stated, his family is the one usually feeding him. During a concurrent observation and interview on 4/19/2026 at 12:40 PM with Resident 6's Family Member 1 (FM 1) inside Resident 6's room, FM1 was observed feeding Resident 6. FM 1 stated it usually took a long time to feed Resident 6. FM 1 stated it took patience and time to provide care for Resident 6. FM 1 stated some of the CNAs (unidentified) did not take time to feed Resident 6. FM 1 stated it is stressful not knowing if they are caring for him or not when I am not here, I can't be here all the time. During an interview on 4/19/2026 at 4:10 PM with the Director of Nursing (DON), the DON stated Resident 6 was confused and was dependent on staff for care and activities. The DON stated it was the facility's staff's responsibility to ensure Resident 6's care and needs were met. During a review of the facility's Policy and Procedure (P&P) titled Activities of Daily Living (ADLs), Supporting revised on 8/26/2025, the P&P indicated Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The P&P indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care); mobility (transfer and ambulation, including walking); elimination (toileting); dining (meals and snacks); and communication (speech, language, and any functional communication systems). The P&P indicated interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 90) reviewed for urinary indwelling catheter (a flexible tube that is inserted through the urethra [passageway between the bladder and the external part of the body, which allows urine to be excreted from the body] and into the bladder and left in place to drain urine) received the necessary urinary catheter care by failing to: -Ensure Resident 90's urinary catheter drainage bag did not touch the floor. This failure placed Resident 90 at risk for urinary tract infection (infection caused by bacteria). Findings: During a review of Resident 90's admission Record, the admission Record indicated the facility originally admitted Resident 90 on 2/7/2020 and readmitted on [DATE] with diagnoses including hydronephrosis with renal and ureteral calculous obstruction (when kidney stones are causing a blockage in the tube draining the kidney, causing the kidney to swell with trapped urine), encounter for surgical aftercare following surgery on the genitourinary system (postoperative care on keeping the urinary system clean, preventing infection, and reducing pressure on the healing area), and agoraphobia (an anxiety [nervous] disorder characterized by an intense fear of being in situations where escape might be difficult or help unavailable if a panic attack occurs). During a review of Resident 90's Minimum Data Set (MDS- a resident assessment tool) dated 2/16/2026, indicated Resident 90 required extensive assistance to total dependence from staff for activities of daily living (ADL- bed mobility, transfer, dressing, toilet use, and personal hygiene). During a review of Resident 90's History and Physical (H&P) dated 4/13/2026, the H&P indicated Resident 90 had a history of hydronephrosis and had the capacity to make medical decisions. During a facility tour observation on 4/18/2026 at 9:26 AM, the surveyor observed Resident 90's urinary catheter drainage bag hanging on the side of the bed and was touching the floor. During a concurrent observation and interview on 4/19/2026 at 12:01 PM inside Resident 90's room with Treatment Nurse 1 (TN 1), TN 1 stated Resident 90's urinary catheter drainage bag was touching the floor. TN 1 stated the urinary catheter drainage bag should not be touching the floor for infection control and prevention purposes. During an interview on 4/19/2026 at 4:57 PM with the Director of Nursing (DON), the DON stated the urinary catheter drainage bag should not touch the floor or be placed on a basin to protect residents (in general) from urinary tract infections. During a review of facility's policy and procedure (P&P), titled Catheter Care, Urinary, reviewed on 8/2025, the P&P indicated: The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection Control: be sure the catheter tubing and drainage bag are kept off the floor.

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	055870	A. Building B. Wing	04/19/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe medication administration or accurate accountability of all controlled medications (medications with a high potential for abuse) for one of four sampled residents (Resident 6) by failing to:-Document the removal of Lacosamide (a medication used for seizure disorder, a condition characterized by abnormal electrical activity in the brain that leads to sudden changes in behavior, movement, feelings, or consciousness) for administration to Resident 6 on the Controlled Drug Record (CDR, a detailed record that tracks the receipt, administration, disposal, and inventory of controlled substances [use are regulated by law due to its potential for abuse, dependence, or harm]).This failure had the potential for unsafe care, treatment, and medication administration which could result in Resident 6 receiving more or less medication than needed to control seizures. This failure created a discrepancy between Resident 6's Medication Administration Record (MAR, a record of each medication given, including dosage, time, and the person administering) and the CDR on 4/2/2026 and 4/4/2026. This failure increased the risk for the licensed nurses (in general) not to be able to readily identify controlled medication loss, drug diversion (illegal distribution or use of prescription drugs), or medication errors.Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility admitted Resident 6 on 10/4/2024 and readmitted Resident 6 on 1/24/2026 with diagnoses that included seizures and encounter for attention to gastrostomy tube (G-Tube, a medical device inserted through the abdomen for nutrition, fluids, or medication administration). During a review of Resident 6's Care Plan Report dated 4/5/2025, the Care Plan Report indicated Resident 6 was at risk for injury related to seizure disorder. The Care Plan Report indicated the goal was for the resident not to experience an adverse reaction (an unpleasant symptom or event that is due to or associated with a medication) to medication. The Care Plan Report indicated the nursing interventions included to administer medications as ordered and monitor for side effects. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool) dated 12/9/2025, the MDS indicated Resident 6's cognition (ability to think, remember, and reason) was severely impaired, and Resident 6 needed substantial to maximal assistance (staff does more than half the effort) for eating and oral hygiene, and was dependent (staff does all the effort) for toileting, shower, dressing, personal hygiene, and transfer from bed to chair. During a review of Resident 6's Order Summary Report, the Order Summary Report indicated on 1/24/2026, Resident 6's physician ordered Lacosamide Oral Solution 10 milligrams (mg, unit of mass) per milliliters (ml, unit of volume), to give 20 ml via G-Tube every 12 hours for seizure disorder. During a review of Resident 6's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status) dated 1/26/2026, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a concurrent medication area observation, record review, and interview on 4/18/2026 at 11:55 AM, with a Licensed Vocational Nurse 3 (LVN 3), on Station A at Medication Cart 1 (MedCart1), Resident 6's CDR and MAR for the Month of April 2026 were reviewed for the administration of Lacosamide. LVN 3 compared the 4/4/2026 MAR and CDR for Resident 6's Lacosamide and stated Resident' 6s MAR had two doses documented as administered on 4/4/2026 (timed at 9 AM and 9 PM) and the CDR indicated one dose of Lacosamide for Resident 6 was documented on the CDR on 4/4/2026 (timed at 9 PM). LVN 3 stated that there were no licensed nurse initials on the CDR to indicate Resident 6's Lacosamide was removed for administration on 4/4/2026 for the scheduled 9 AM dose. LVN 3 stated if the licensed nurse (unidentified) did not document then it did not happen. During a concurrent interview and record review on 4/18/2026 at 6:11 PM with the Director of Nursing (DON), Resident 6's MAR and CDR for the Month of April 2026 were reviewed. The DON stated Resident 6's MAR indicated by documentation that Resident 6 was received two doses of Lacosamide on 4/2/2026 and on 4/4/2026 each day at 9 AM and 9 PM but the licensed nurses (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(unidentified) did not sign for the removal of each dose on the CDR. The DON stated for Resident 6 one dose of Lacosamide was documented as removed for administration to the resident on 4/2/2026 at 9 AM and there was no CDR documentation for the scheduled 9 PM dose of Lacosamide on 4/2/2026. The DON stated for Resident 6 one dose of Lacosamide was documented as removed for administration to the resident on 4/4/2026 at 9 PM and there was no CDR documentation for the scheduled 9 AM dose of Lacosamide on 4/4/2026. The DON stated the purpose of the CDR was to reconcile (the process of reviewing and verifying a patient's medications to ensure accuracy, safety, and proper coordination across different healthcare providers) with the resident's MAR to make sure the medication was removed and administered to the resident. During a review of Resident 6's MAR and CDR for the Month of April 2026, the following discrepancies were noted:Resident 6's MAR for the Month of April 2026 indicated by documentation and licensed nurses' initials (unidentified) that the resident was administered Lacosamide as follows:a. Two doses of Lacosamide on 4/2/2026 for scheduled administration at 9 AM and 9 PMb. Two doses of Lacosamide on 4/4/2026 for scheduled administration at 9 AM and 9 PM Resident 6's CDR for the Month of April 2026 indicated by documentation and licensed nurses initials the following discrepancy with the MAR:a. One dose of Lacosamide was documented removed on the CDR for administration on 4/2/2026 at 9:00 AM for 20 ml to Resident 6. There were no licensed nurse initials on Resident 6's CDR on 4/2/2026, for the scheduled 9 PM dose of Lacosamideb. One dose of Lacosamide was documented removed on the CDR for administration on 4/4/2026 at 2100 (9:00 PM) for 20 ml for Resident 6. There were no licensed nurse initials on Resident 6's CDR on 4/4/2026, for the scheduled 9 AM dose of Lacosamide. During a review of the facility's policy and procedures (P&P) titled, Controlled Substances, review date 8/28/2025 indicated The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976).If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance. Do not enter more than one (1) prescription per page. This record contains:Name of the residentName and strength of the medicationQuantity receivedNumber on handName of the prescriber.Time of administrationmethod of administration.signature of nursing administering medication.Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up.The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following:Records of personnel access and usageMedication administration recordsDeclining inventory recordsDestruction, waste and return to pharmacy records.If major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately.The medication regimen of residents using medication that have such discrepancies are reviewed to assure the resident has received all medications ordered and the goal of therapy is met.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to ensure that a licensed pharmacist performed a monthly medication regimen review (MRR, when a consultant pharmacist reviews and analyzes a resident's medication list, ensuring that the medications are appropriate, effective, and safe) to identify potential clinically significant medication issues, including unnecessary drugs, for one of 18 sampled residents (Resident 4). This failure had the potential to result in unmonitored adverse drug reactions (undesired and harmful effects that occur because of medication, treatment, or procedure) and inappropriate medication usage for Resident 4.Findings: During a review of Resident 4's admission Record, the admission Record indicated the facility admitted Resident 4 on 11/22/2024 with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), hypertension (HTN-high blood pressure), and hypothyroidism (a condition where the butterfly-shaped gland in your neck doesn't produce enough hormones, causing your body's metabolism to slow down). During a review of Resident 4's Order Summary Report dated 12/3/2025, the Order Summary Report indicated Risperidone [medication used to treat schizophrenia] Oral Tablet (Risperidone)ˆGive 1 mg [milligrams-unit of measure] by mouth two times a day for Schizophrenia M/B [manifested by] sudden angry outburst. During a review of the facility binder for Consultant Pharmacist's Medication Regimen Review [MRR] for recommendations created between 12/1/2025 and 12/12/2025, the MRR indicated Resident 4's name was listed among 35 other residents (unidentified) as medications that were reviewed by the consultant pharmacist but did not require any recommendations. During a review of Resident 4 ' s Minimum Data Set (MDS - a resident assessment tool) dated 2/13/2026, the MDS indicated Resident 4 was cognitively intact (was able to understand and make decisions independently). The MDS indicated Resident 4 required staff supervision or touching assistance for Activities of Daily Living (ADLs such as, toileting hygiene, shower/bathe self, personal hygiene, putting on/taking off footwear, personal hygiene, lower/upper body dressing). During a concurrent interview and record review of the facility binder for MRR with the Director or Nursing (DON) on 4/19/2026 at 7:12 PM, the DON was unable to locate the MRR for Resident 4's risperidone. During a follow up concurrent interview and record review with the DON on 4/19/2026 at 7:24 PM, the DON presented Resident 4's MRR for a different medication (Primidone 250 mg- an anti-seizure medication or an anticonvulsant that works by calming overactive nerves in the brain) and provided the consultant pharmacist's MRR list which did not indicate or specify which medications were reviewed. The MRR did not indicate Resident 4's response to the Risperdal. The DON stated that the importance of conducting an MRR was to ensure that residents (in general) who would take high risk medications (drugs with a heightened risk of causing significant patient harm, or even death, when used in error) such as antipsychotics (Risperdal) were monitored for side effects and checking the appropriateness of continuing therapy. The DON was unable to respond when asked what the potential effects were of not completing a pharmacy MRR monthly. During a review of the policy and procedure (P&P) titled, CONSULTANT PHARMACIST REPORTS. IIIAla: MEDICATION REGIMEN REVIEW (MONTHLY REPORT) reviewed 8/18/2025, the P&P indicated The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. The P&P indicated that the consultant pharmacist had to review the MRR monthly for each resident either onsite or remotely to access clinically relevant information.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of 36 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) met the 80 square feet (sq. ft.) per resident. room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] consisted of three-bedroom capacity. This failure had the potential to result in inadequate space to provide safe nursing care and privacy for the residents (unidentified) who resided in room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER].Findings:During a review of the facility's untiled room waiver letter dated 4/19/2026, the room waiver letter indicated the facility requested a room waiver for three resident rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]). The room waiver letter indicated room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] had three resident beds and measured 231 square feet, which equaled to 77 square feet per bed (the minimum requirement for a 3 bedroom should be at least 240 square feet). The room waiver letter indicated room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] were free of projections or other obstructions that could impede safe and independent movement of wheelchairs and /or other mobility devices. The room waiver letter indicated room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] provided sufficient space to deliver resident care in a dignified manner while maintaining privacy. The room waiver letter indicated the individual needs of residents (unidentified) who occupied room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] could be met safely and appropriately, with care delivered in a manner that supported each resident in achieving his or her highest practicable level of functional ability and overall well-being. During the initial tour observation of the facility on 4/18/2026 from 9:30 AM to 12:30 PM, the surveyors observed room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] and observed that nursing staff (in general) had enough space to provide care to the residents (unidentified), there were curtains to provide privacy for each resident and the rooms had direct access to the corridors. During the group interview with the residents (Resident 11, Resident 31, Resident 38, Resident 54, Resident 58, and Resident 63) on 4/19/2026 at 11:11 AM, no concerns were brought up regarding the size of the rooms. The Department is recommending approval of the room waiver request.