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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056488	A. Building B. Wing	05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Nursing Center	22617 So. Vermont Ave Torrance, CA 90502

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45425 Based on interview and record review, the facility failed to provide care consistent with professional standards for one of three sampled residents (Resident 1). The facility failed to: a. Inform Resident 1's physician regarding the removal of Resident 1's Peripherally inserted central catheter ([PICC] thin, soft tube inserted into the resident's vein for long term medication, nutrition, and blood draws) line. b. Monitor and assess the PICC line site after removal. This deficient practice placed Resident 1 at risk for bleeding and infection after the removal of the PICC line. Findings During a review of Resident 1's Admission Record, the record indicated Resident 1 was admitted on [DATE] with the diagnosis of osteomyelitis (swelling of bone tissue that is usually the result of an infection) of the vertebra (spine). During a review of Resident 1's Minimum Data Set ([MDS]- a standardized assessment and care screening tool), dated 4/10/2024, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. During a review of Resident 1's physician order, dated 4/4/2024, the order indicated to monitor intravenous ([IV] soft flexible to inserted in the vein to give a person medicine or fluids) site and document for signs and symptoms such as redness, swelling, infiltration (when fluid licks into the tissues) and bleeding every shift and notify physician for any abnormal changes every shift. During a review of Resident 1's untitled Care Plan dated 4/4/2024, the care plan indicated indicated Resident 1 was on IV antibiotics for vertebral (spine) osteomyelitis. The Care Plan indicated Resident 1 had a PICC line. Under this Care Plan a goal was for Resident 1 was to be free from complications of IV administration through the course of treatment. The Care Plan's interventions included observing the IV site every shift and to report to the physician as indicated, and if the catheter was accidentally removed, pressure should be applied to the site with a sterile gauze and the physician should be notified. (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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's IV Administration record for 5/5/2024, the record indicated 9 representing the licensed nurse entered a progress note on that date. During a review of Resident 1's Electronic Medication Administration (EMAR) progress note, dated 5/5/2024, the note indicated Resident 1 did not have an IV line. During an interview on 5/7/2024 at 3:04 p.m. with Resident 1, Resident 1 stated he did not know what happened to the PICC line that was in his right upper arm. Resident 1 stated that one night the PICC line was no longer in the resident's arm, and it was on the floor. During an interview and concurrent record review of Resident 1's (EMAR) progress notes on 5/7/2024 at 3:10 p.m. with Registered Nurse Supervisor 1 (RNS 1), the RNS 1 stated that she documented Resident 1 no longer had the PICC line which she documented in the EMAR. RNS 1 stated that she discontinued the order to monitor the IV site because it was no longer needed since the resident did not have the PICC line anymore. RNS 1 stated the physician was not notified the PICC line was removed. During an interview on 5/8/2024 at 1:03 p.m. with the Unit Manager 1 (UM 1), the UM 1 stated there were no orders to discontinue Resident 1's PICC line. The UM 1 stated she was investigating why the PICC line was discontinued. The UM 1 stated there was no documentation regarding informing the physician or any monitoring of the site after removal of the PICC line. The UM 1 stated the site should be monitored after removal because it could be bleeding and swelling. During an interview on 5/8/2024 at 2:00 p.m. with the Senior Head Nurse (SHN), the SHN stated when a PICC line was removed the line needs to be measured to ensure its removed intact, the resident needs to be assessed and monitored to ensure there is no bleeding or swelling, and the physician should be notified for any additional orders. During a review of the facility's Policy and Procedure (P/P) titled Central Venous Catheter Care and Dressing Changes dated 3/2022, the P/P indicated the licensed staff should report any signs and symptoms of complications to the physician, supervisor, and oncoming shift.