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	07/25/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to provide necessary care and services for one of three sampled residents (Resident 1) by failing to: a.Notify the physician when Resident 1 had episodes of loose watery stool in a timely manner. b.Administer insulin (medication used to treat high blood sugar) as ordered by the physician on 7/21/2024 at 12:00 p.m. dose. c.Notify the physician when Resident 1's blood sugar remained high despite administration of insulin. These failures had the potential for Resident 1 to have elevated blood sugar level that can lead to worsening of his condition. Resident 1 was transferred to general acute care hospital (GACH) for management of high blood sugar and infection. 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 hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (damage to the brain from interruption of its blood supply) affecting right dominant side (right side) diabetes mellitus(high blood sugar), congestive heart failure (condition that develops when the heart does not pump enough blood to meet the body's needs),and bacteremia (presence of bacteria in the blood). During a review of Resident 1's Minimum Data Set ([MDS] a standardized assessment and care screening tool) dated 7/22/2024, the MDS indicated Resident 1 was able to make decision regarding tasks of daily life and was dependent on staff with toileting hygiene, bathing, transferring from bed to a chair. The MDS indicated the resident was frequently incontinent (having no or insufficient voluntary control over urination or defecation) of stool and urine. During a review of Resident 1's stool exam for clostridium difficile ([c diff] highly contagious bacterial infection of the colon and caused symptoms such as diarrhea, and stomach pain) collected on 7/22/24, the stool exam indicated Resident 1 had c difficile infection. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 1's Bowel and Bladder Elimination, the Bowel and Bladder Elimination indicated the following: On 7/18/2024, Resident 1 had one watery episode of watery stool. On 7/21/2024, Resident 1 had 2 episodes of watery stool On 7/23/2024, Resident 1 had one episodes of soft stool and 2 episodes of watery stool. During a review of Resident 1's Change in Condition Evaluation ([COC] a sudden clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional condition) dated 7/22/204 at 3:26 p.m., the COC indicated Resident 1 had loose stools and the physician was notified. The COC indicated stool exam for Clostridium difficile was ordered. During an interview on 7/24/2024, at 5:15 p.m. with Certified Nursing Assistant (CNA 4) , CNA 4 stated Resident 1 had watery bowel movement and was reported to Licensed Vocational Nurse(LVN 2) on 7/21/2024. CNA 4 stated on 7/22/2024 , Resident 1 was a little drowsy and had 3 episodes of yellow and watery stools. CNA 4 stated it was important to report to the charge nurse and Registered Nurse Supervisor any changes on resident to ensure the resident will get appropriate treatment needed. During an interview on 7/24/2024, at 10:47 a.m., with CNA 3, CNA 3 stated Resident 1 was incontinent of urine and stool. CNA 3 stated he had notified LVN 2 about Resident 1's diarrhea and decreased appetite on 7/22/2024. During an interview on 7/24/2024, at 5:20 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated CNA 3 notified her on 7/22/2024 Resident 1 had 2 episodes of watery and foul-smelling stool. LVN 2 stated she did not remember if the resident was on antibiotic. LVN 2 stated residents who were on antibiotic were monitored for adverse reactions like hives, nausea, vomiting, stomach pain, loose stools, or C. difficile infection. During a telephone interview on 7/25/2024, at 10:13 a.m. with RN Supervisor (RNS 3), RNS 3 stated she did not know Resident 1 had episodes of watery stool. RNS 3 stated RNS 3 stated the certified nursing assistant should notify the charge nurse for any change of condition like presence of watery stools and the charge nurse will assess to verify, will do COC, and notify the physician right away. RNS 3 stated it was important to notify the doctor and do the COC so the resident can be monitored, and treatment plan will be implemented accordingly. During a concurrent interview and record review with RNS 1, RNS 1 confirmed Resident 1 had 2 episodes of watery stool on 7/21/2024. RNS 1 stated COC should have been done and physician notified right away. b. During a review of Resident 1's MAR for July 2024, the MAR indicated Resident 1 was on the following medications for diabetes: 1. Humalog (short acting insulin) inject 10 units(unit- amount of insulin) subcutaneously (sq- needle is injected under the skin) one time a day for diabetes scheduled at 7:15 a.m. 2. Humalog 12 units sq at lunch scheduled at 12:00 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Humalog 18 units sq one time a day scheduled at 5:00 p.m. 4. Humalog Kwik pen(small, lightweight pen prefilled with insulin) sq inject per sliding scale: If blood sugar is 150 - 200 milligrams/ deciliter(mgs and dl -unit of measurement) give 2 units of Humalog. Blood sugar of 201 -250= 4 units Blood sugar of 251-300= 6 units Blood sugar of 310- 350 = 8 units Blood sugar of 351- 400 = 10 units sq before meals and at bedtime for diabetes if blood sugar is less than 60 mgs/dl give orange juice and if blood sugar is > 400 mgs/dl , call the doctor. 5.Semglee(long-acting insulin) 22 units sq one time a day for diabetes scheduled at 7:15 a.m. 6. Semglee 18 units sq at bedtime for diabetes scheduled at 9 p.m. During a review of Resident 1's COC dated 7/21/2024, at 12:00 p.m., the COC indicated Resident 1 had elevated blood sugar, (no documenatuion of the blood sugar level. The COC indicated the routine long-acting insulin (Semglee) will be increased to 24 units in the morning and 18 units at bedtime. During a review of Resident 1's MAR dated 7/21/2024, the MAR indicated Resident 1 did not receive the dose for 11:45 a.m. Humalog 12 units sq with lunch. During a concurrent interview and record review on 7/24/2024, at 2:29 p.m. with RNS 1 reviewed Resident 1's EHR RNS 1 confirmed no blood sugar reading was documented on 7/21/2024 at 12:00 p.m. and the resident Resident 1 did not receive the scheduled Humalog 12 units sq with lunch. RNS 1 confirmed there was no documentation of Resident 1's blood sugar reading and administration of Humalog insulin on 7/21/2024 at 11:30 a.m. During a concurrent interview and record review on 7/25/2024, at 4:30 p.m. with Senior Nursing Executive (SNE), Resident 1's MAR and blood sugar logs was reviewed for 7/21/2024. SNE confirmed there was no blood sugar reading for 12:00 p.m. and scheduled Humalog injection and sliding scale Humalog was not documented as given. SNE stated she updated and closed the COC done on 7/21/2024 because it was incomplete. SNE agreed the documentation was missing and not sure if the insulin was administered to Resident 1 . SNE stated if it was not documented on the MAR then the insulin was not administered. During an interview on 7/25/2024, at 4:45 p.m. with Chief Clinical Officer (CCO), CCO stated it was important to have an accurate documentation on the MAR so the staff could reference back what was the blood sugar and check what kind of intervention or treatment was provided to the resident. c.During a review of Resident 1's blood sugar log for 7/21/2024 to 7/22/2024the blood sugar results indicated: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. 7/21/2024 12:00pm - no result 2. 7/21/2024 6:36 p.m.- 391 mg/dl 3.7/21/2024 8:35 p.m.- 366 mg/dl 4. 7/21/2024 6:58 a.m. - 395 mg/dl 5. 7/22/2024 -12:09 p.m.- 485 mg/dl 6. 7/22/2024 4:29 p.m.- 331 mg/dl During a review Resident 1's COC dated 7/22/2024, the COC indicated the Resident 1 had elevated blood sugar (485 mg/dl) and the physician was notified on 7/22/2024 at 12:10 p.m. The COC indicated the resident received 12 units of scheduled Humalog sq for 12:00 p.m. and 10 units of Humalog sq based on the sliding scale order. The COC indicated at 12:10 p.m. the physician was in the facility and was notified about elevated blood sugar . The COC indicated blood sugar was 480 mgs/dl. after 30 minutes of administering the insulin and was relayed to the nurse practitioner (nurse who has advanced clinical education and training). The nurse practitioner ordered to recheck Resident 1's blood sugar in one hour and it resulted to 392 mgs/dl. During a concurrent interview and record review on 7/24/2024, at 2:29 p.m. with RNS 1, reviewed Resident 1 MAR. RNS 1 confirmed on 7/21/2024 Resident 1 did not receive insulin for 12:00 p.m. dose and stated resident's blood sugar was not controlled. RNS 1 stated the licensed nurse should notify the physician right away if the blood sugar was not controlled and managed well because current treatment and intervention was not effective in controlling the blood sugar. RNS 1 stated if blood sugar was uncontrolled the resident should be transferred to the GACH for further management. RNS 1 stated Resident 1's stool exam taken on 7/22/2024 was positive for C. difficile infection and infection could cause high blood sugar or development of diabetic ketoacidosis(DKA, complication of diabetes in which acids build up in the blood to levels that can be life threatening). During a review of Resident 1's COC dated 7/22/2024 timed at 8:00 p.m. the COC indicated Resident 1 was lethargic (lack of energy) and tachycardic (fast heart rate) with a pulse rate of 117 per minute, blood sugar was 341 mg/dl. The COC indicated the family notified the RN Supervisor about Resident 1's decrease in appetite and weakness. The COC indicated the resident noted to be tachycardic and blood sugar was 341 mg/dl at 8:15 p.m. taken by the RN Supervisor. The COC indicated the physician was notified and the facility called 911(emergency medical number). Resident 1 was transferred out to GACH on 7/22/2024. During a review of Resident 1's GACH History and Physical (H &P) dated 7/22/2024,the H&P indicated Resident 1 was on DKA, positive for ketones in the urine(if cells could not get enough glucose the body breaks down fat for energy and this produces an acid called ketones which can buildup in the urine and blood), tachypnea(rapid breathing), tachycardia) and metabolic acidosis(condition in which there was too much acid in the body). The H&P indicated Resident 1 was started on insulin drip (intravenous infusion of insulin to quickly bring down high blood sugar). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled Condition Change of Resident revised 11/2016, the P&P indicated the facility will observe, record and report changes in condition to the physician. The P&P indicated a change of condition can be anything that deviates from a resident's baseline status that requires further assessment and physician notification. During a review of facility's P&P titled Clostridium Difficile revised 10/2018, the P&P indicated clostridium difficile infection is suspected in residents with acute, unexplained onset of diarrhea. The P&P indicated steps toward prevention and early intervention include ongoing surveillance of Clostridium difficile infection and increasing awareness of symptoms and risk factors among staff, residents, and visitors. During a review of facility's P&P titled Quality of Care updated 1/30/2023, the P&P indicated the facility must ensure the residents will receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45269 Based on observation, interview, and record review, the facility failed to observe infection prevention and control measures by failing to: a. Conduct fit testing (test to ensure they are wearing the proper size respirator to seal and prevent particles, that may cause infection, from entering the respiratory system) for a N95 mask (filtering facepiece respirator) on six of 10 staff members. b. Handle soiled linens in a safe and sanitary way by staff swinging the plastic linen bag back and forth towards the body before disposing it in a barrel outside the facility. These deficient practices had the potential to place residents at risk for the spread of infection and result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another). Findings: a. During a concurrent interview and record review with Infection Preventionist Nurse (IPN) reviewed N95 Mask Fit Test Log. IPN confirmed six staff members were not up to date with their N95 mask fit test (method of finding a right respirator that can provide a tight seal and protect the wearer protection from germs and prevent spreading germs to others). IPN stated N95 Fit Test for employees is done upon hire and annually. IPN stated N95 Fit Testing is performed to ensure protection against Covid-19 (highly contagious infection caused by a virus and affects the lungs) and other respiratory illnesses. IPN stated Fit Testing of N95 mask is important because it will ensure the staff will use a respirator with an adequate and good seal. During an interview on 7/24/2024, at 2:15 p.m. with RN Supervisor (RNS1), RNS 1 stated it was important to have N95 mask fit testing to ensure the staff would have the right size of the mask for protection against Covid-19 (a highly contagious infection, caused by a virus that can easily spread from person to person) and other diseases. RNS 1 stated staff members could get sick if they are wearing the incorrect size of the mask. b. During an observation on 7/24/2024, at 9:10 a.m. Certified Nursing Assistant (CNA1) stepped out of a resident ' s room holding a small plastic bag with white clothing inside. CNA 1 was walking towards the hallway swinging the plastic bag back and forth towards her body and disposed the plastic bag in a barrel outside the facility. CNA 1 stated the plastic bag contains dirty bibs used on residents and did not know why she was swinging the bag filled with dirty bibs. CNA 1 stated she should have not swung the bag because the dirty bibs could break open the plastic bag and contaminate the surrounding area which could be a source of infection. During an interview on 7/24/2024, at 9:28 a.m. with IPN, IPN stated the facility had a communal barrel in the hallway and barrels in the patio. IPN stated the staff members should not agitate the linen and swing the bag filled with dirty bibs back and forth towards one ' s body because of the possibility of breaking the plastic bag which could result into contaminating the surrounding area and spreading infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility ' s policy and procedure (P&P) titled Fit Test Policy revised 3/2021, the P&P indicated The facility to reduce employee ' s exposure to infectious agents in the workplace trough the proper use of respirators during an influenza (infection of the nose, throat and lungs that is contagious and caused by a virus) pandemic, or other infectious respiratory disease. During a review of facility ' s P&P titled Laundry and Bedding, Soiled revised 10/2018, the P&P indicated soiled laundry / bedding should be handled, transported, and processed according to best practices for infection prevention and control. The P&P indicated all used laundry is handled as potentially contaminated and should be handled as little as possible, with minimum agitation or held close to the body or squeezed during transport.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review the facility failed to implement their antibiotic stewardship program (measures used by the facility to ensure antibiotics [drug to treat infection] are used only when necessary and appropriate) on one of three sampled residents (Resident 1) by failing to monitor and address antibiotic (a substance used to kill bacteria and to treat infection) use. This failure had the potential for the resident to receive an inappropriate antibiotic and develop clostridium difficile infection ([C diff] highly contagious bacterial infection of the colon and caused symptoms such as diarrhea, and stomach pain). Findings: During a review of Resident 1 ' s Admission Record, the Admission Record indicated the resident was admitted on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (partial weakness of the right side of the body after a stroke), , diabetes mellitus(high blood sugar), congestive heart failure(condition that develops when the heart does not pump enough blood to meet the body ' s needs),and bacteremia (presence of bacteria in the blood). During a review of Resident 1 ' s Minimum Data Set ([MDS] standardized assessment and care screening tool) dated 7/22/2024, the MDS indicated the resident was able to make decision regarding tasks of daily life and was dependent on the staff with toileting hygiene, bathing, transferring from bed to a chair. The MDS indicated the resident was frequently incontinent (having no or insufficient voluntary control over urination or defecation) of stool and urine. During a review of Resident 1 ' s General Acute Hospital Records (GACH) titled Discharge Summary Home Health/ Nursing Home Orders dated 7/17/2024, the Discharge Summary indicated the resident had blood culture (laboratory test used to detect infection in the blood) dated 7/11/2024 without growth of bacteria and another blood culture was performed on 7/16/2024 with pending results. During a review of facility ' s Infection Prevention and Control Surveillance Log, the Infection Prevention and Control Surveillance Log indicated resident was not monitored for its use of Amoxicillin (antibiotic). During a review of Resident 1 ' s stool exam for clostridium difficile collected on 7/22/24, the stool exam indicated Resident 1 had the c difficile infection. During a review of Resident 1 ' s Medication Administration Record (MAR) for July 2024, the MAR indicated an order of Amoxicillin (medicine use to treat infection) oral capsule one capsule by mouth three times a day for bacteremia for 7 days. The MAR indicated Resident 1 received Amoxicillin on 7/18/2024, 7/19/2024, 7/20/2024. 7/21/2024 and 7/22/2024. During an interview on 7/24/2024, at 5:15 p.m. with CNA 4, CNA 4 stated on the day Resident 1 was transferred to GACH, the resident had three watery stools and was a little sleepy. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent interview and record review of Resident 1 ' s electronic chart on 7/24/2024 at 2:29 p.m. and on 7/25/2024, at 1:29 p.m. with RN Supervisor (RNS1), RNS 1 confirmed the resident was positive for C difficile infection based on the stool exam sent on 7/22/2024. RNS 1 stated all licensed nurses were trained on how to fill out an infection Surveillance Checklist for antibiotic usage and validated no documentation about Infection Surveillance for Resident 1 regarding the usage of Amoxicillin. RNS 1 stated it was important to monitor usage of antibiotic to prevent residents from developing multi drug resistant organism (MDRO, bacteria that had become resistant to a lot of antibiotics and can be difficult to treat). During a concurrent interview and record review of Resident 1 ' s electronic chart on 7/24/2024, at 4:30 p.m. and 7/25/2024, at 4:19 p.m. with Infection Preventionist Nurse / Regulatory Nurse Compliance Nurse (IPN/RCN), IPN confirmed there were no documents or surveillance data indicating Resident 1 ' s use of Amoxicillin was monitored or reviewed. IPN stated the facility will review antibiotic use by checking signs and symptoms, laboratory test result that was used as a basis or indication for the antibiotic usage. IPN stated Resident 1 ' s antibiotic order came from the hospital and the facility should have obtained any laboratory results from the hospital to ensure the usage of antibiotic was appropriate. IPN confirmed the results of blood cultures done in GACH was negative. IPN stated the facility should have done the Infection Surveillance Monitoring and verified with the physician regarding the use of Amoxicillin for Resident 1. IPN stated inappropriate use of antibiotic and not monitoring the usage could cause MDRO, adverse effects and c difficile infection. During a review of facility ' s policy and procedure (P&P) titled Antibiotic Stewardship revised 8/2023, the P/P indicated the facility will monitor the use of antibiotics as part of antibiotic stewardship program and will emphasize the importance of antibiotic stewardship and how inappropriate use antibiotics could affect individual residents and the overall community. The P&P indicated training and education will include emphasis on the relationship between antibiotic use and gastrointestinal disorders, opportunistic infections like C. difficile, medications interactions and evolution of drug resistant organisms.