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	01/07/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to implement resident centered care plans for one of three sampled residents (Resident 1) who had a history of a craniectomy (procedure which permanently removes a portion of the skull to access the brain) and pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) by failing to: 1. Ensure Resident 1 ' s Responsible Party (RP) 1 was provided updates regarding Resident 1 ' s wound care treatments as agreed upon during the Interdisciplinary team meeting (IDT health care professionals from different professional disciplines who work together to manage resident goals) meeting held on 11/1/2024. 2. Ensure Resident 1 was wearing a helmet during her transport to the General Acute Care Hospital (GACH) 2 on 11/7/2024. These failures resulted in violating Resident 1 and RP 1 ' s rights to actively participate in Resident 1 ' s plan of care and had the potential for Resident 1 to have a head injury from lack of head protection upon transportation to the GACH. Findings: a. During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and tracheostomy (surgical opening into the neck to help someone breath). During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/29/2024, the MDS indicated Resident 1 ' s cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 1 was at risk for developing pressure ulcer/injury and had the following unhealed pressure ulcer/injuries during the assessment period: (continued on next page)

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
	056488	A. Building B. Wing	01/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. One stage 2 (Partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure ulcer/injury. 2. One unstageable (a wound which is unable to determine the full depth due to a layer of dead tissue) pressure ulcer/injury. 3. Two unstageable deep tissue injuries (full thickness [extends through two primary layers of skin potentially reaching muscle, tendon, bone]) loss where depth of wound is hidden by layer of dead tissue) pressure ulcers/injuries. During a review of Resident 1 ' s History and Physical (H&P) dated 11/1/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Care Plan, initiated on 3/22/2024, the Care Plan indicated Resident 1 was noted with a Deep Tissue Pressure Injury (DTPI- where damage occurs to the underlying soft tissues beneath the skin) to the sacrum (a large, triangular bone at the base of the spine which connects to the pelvis). Under this Care Plan interventions included updating the family regarding wound progress and interventions. During a review of Resident 1's Interdisciplinary (IDT - health care professionals from different professional disciplines who work together to manage resident goals) Team Conference Record, dated 11/1/2024 indicated the following persons were present during the meeting, Resident 1 ' s responsible party (RP 1), Treatment Nurse (TN)/Wound Care Coordinator (WCC), and the Unit Director of Nursing (UDON). The IDT Record indicated the goals/evaluations were as follows: as discussed by the WCC and RP 1, RP 1 will receive weekly updates from the treatment nurse after the visit from the physician wound consultant, and any significant changes to be reported to the Power of Attorney (POA) and/or RP1 immediately. During a review of Resident 1's Skin Evaluation Form, dated 11/25/2024, indicated Wound Care Consultant Physician (WCMD) 1 saw Resident 1 on 11/25/2024 and documented Resident 1 ' s sacrococcyx pressure ulcer/injury had had a slight decrease in size. The Skin Evaluation Form did not indicate RP 1 was notified of the WCMDs findings. During a review of Resident 1's Skin Evaluation Form, dated 12/2/2024, indicated a sacrococcyx pressure ulcer/injury measuring 3.5 centimeters (cm-unit of measurement) x 3.8 cm x 1.2 cm, and had a slight decrease in size. The Skin Evaluation Form indicated there was undermining (pocket or dead space under the wound) of 0.4 cm of the sacrococcyx pressure ulcer/injury. The Skin Evaluation Form did not indicate RP 1 was notified of the WCMDs findings. During a review of Resident 1's Skin Evaluation Form, dated 12/2/2024, indicated Resident 1 had a right gluteal pressure ulcer/injury measuring 4.0 cm x 2.0 cm x unable to determine. The Skin Evaluation Form did not indicate RP 1 was notified of the WCMDs findings. (continued on next page)

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	01/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Skin Evaluation Form, dated 12/4/2024, indicated a sacrococcyx wound debridement (procedure that removes infected, damaged, or dead tissue from a wound) was done, and 100 % granulation tissue (new connective tissue that forms in a wound during the healing process) and the muscle tissue had 80% granulation (new connective tissue and microscopic blood vessels that form on the surface of a wound during the healing process) and 20% slough (dead skin cells). The Skin Evaluation Form did not indicate RP 1 was notified of the WCMDs findings. During a review of Resident 1's Skin Evaluation Form, dated 12/14/2024, indicated sacrococcyx wound debridement was done, and 100 % granulation tissue (new connective tissue that forms in a wound during the healing process) was noted with heavy serous drainage (clear or slightly yellow fluid that leaks from a wound). The Skin Evaluation Form did not indicate RP 1 was notified of the WCMDs findings. During a review of Resident 1's Skin Evaluation Form, dated 12/18/2024, indicated Resident 1 ' s sacrococcyx wound was assessed by the Wound Care Consultant and Resident 1 ' s wound measured 7 cm x 6 cm x 2 cm, with undermining of 3 cm from 7 to 10 o ' clock and 12 to 4 o ' clock. The Skin Evaluation Form indicated Resident 1 ' s sacrococcyx wound had 90% granulation tissue with 10% slough (layer of dead skin cells that builds up on the wound bed), and moderate amount of serous drainage. The Skin Evaluation Form did not indicate RP 1 was notified of the Wound Care Consultant ' s findings. During a review of Resident 1's Skin Evaluation Form, dated 12/18/2024 indicated, Resident 1 ' s had a right gluteal wound debridement on 12/4/2024. The Skin Evaluation Form indicated did not indicate RP 1 was notified of the debridement done on 12/4/2024. During an interview on 1/3/2025 at 8:20 a.m., RP 1 stated while visiting Resident 1 during several days in December 2024, RP 1 stated asked the WCC for the details regarding Resident 1 ' s wound treatments. RP 1 stated she asked for details which included wound drainage, size of wounds and how the wounds was cared for. RP 1 stated the WCC was unable to retrieve documentation indicating wound care treatments were provided during the 3 p.m. to the 11 p.m. shift or any other time as needed during the month of December 2024. RP 1 stated she was frustrated because she requested the facility to provide her with regular updates regarding Resident 1 ' s wound care. RP 1 stated she was worried the nursing staff were not treating Resident 1 ' s wounds as ordered by the physician and concerned the nursing staff was not monitoring Resident 1 ' s wounds signs of infection. During an interview on 1/3/2025 at 1:48 p.m., the UDON stated during an IDT meeting with the family in approximately November 2024, the Wound Care Coordinator (WCC), whom is no longer employed at the facility, agreed to provide weekly wound treatment updates to RP 1 pertaining to the status of Residents 1 ' s wounds which included wound measurements and characteristics, updated treatments, physician orders and treatment schedule. The UDON acknowledged the WCC nurse did not provide RP 1 with updates regarding the changes pertaining to Resident 1 ' s wound care treatments. The UDON stated Resident 1 ' s TAR dated 12/1/2024 through 12/31/2024, indicated several changes pertaining to the wound care treatment orders. The UDON stated the facility failed to provide updates to RP 1 indicating the changes in physician ' s wound care orders leading to frustrations and grievances regarding Resident 1 ' s wound care treatments. (continued on next page)

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	01/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/7/2025 at 1 p.m., with the Quality Assurance Nurse (QAN), Resident 1 ' s clinical record was reviewed. The clinical record indicated there was no documentation indicating RP 1 was provided updates by the WCC or any other licensed nurse after Resident 1 was assessed by the WCC, physician or during the weekly skin assessments. The QAN stated RP 1 should have received updates from the nursing staff when the wound care consultant visits and after weekly wound assessments are completed by the treatment nurse as discussed during the IDT meeting held on 11/1/2024. b. During a review of Resident 1's Care Plan initiated on 3/22/2024, the Care Plan indicated Resident 1 was to wear her helmet when she is out of bed, during transfers, and when sitting upright. During a review of Resident 1's Physician ' s Orders dated 10/7/2024, indicated to transfer Resident 1 to a GACH 2 via 911 due to Resident 1 having tachycardia (increased heart rate), lethargy (low energy), hold all orders, and bed hold for seven days, ordered on 10/7/2024. During an interview on 1/3/2025 at 8:20 a.m., RP 1 stated on 10/7/2024 during the process of Resident 1 ' s transfer from the facility to the GACH 2, the facility did not ensure Resident 1 was wearing her helmet as ordered. RP 1 stated Resident 1 is supposed to wear her helmet to protect her head from injury since she is missing part of her skull. RP 1 stated Resident 1 is at risk for head injury due to the facility ' s lack of care. During an interview on 1/7/2025 at 4:30. p.m., the Director of Nursing (DON) stated Resident 1 had a craniectomy prior to her admission to the facility and is missing part of her skull. The DON stated Resident 1 must wear her helmet when not in bed and during transfers. The DON stated Resident 1 was not wearing a helmet during her transport to GACH 2 on 10/7/2024. The DON stated the facility put Resident 1 at risk for brain injury upon transport to the GACH 2 via ambulance to GACH 2 due to lack of protection. During a review of the facility ' s Policy and Procedure (P&P) titled, Wound Care Suggestion and Documentation, revised October 2021, the P&P indicated wounds should be measured and reviewed weekly for improvement or decline as per documentation guidelines. The wound bed will be observed for improvement or decline with dressing changes and treatment orders will be changed accordingly. The P&P indicated, wounds are dynamic and change quickly. The physician should be notified for changes in the wound (improvement or decline) that necessity changes in order to update. The primary care provider and family notification of wound care shall be documented in the appropriate section of the chart. During a review of the facility ' s P&P titled, Resident Participation-Assessment/Care Plan, revised 10/2/2024, the P&P indicated the resident, or her representative are encouraged to participate in the resident ' s assessment and in the development and implementation of the resident ' s care plan. The P&P indicated, the care plan process will facilitate the inclusion of the resident/RP, include an assessment of the resident ' s strengths and needs, incorporate the resident ' s personal, cultural preferences in establishing goals of care. During a review of the facility ' s P&P titled, Quality of Care, revised 11/6/2024, the P&P indicated it is the policy of this facility to provide all necessary treatment and care to the residents based on thorough assessments, professional practice standards, personalized care plans and the residents ' individual choices and preferences.

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	01/07/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure nursing staff did not reverse (incorrectly classifying a healing pressure ulcer/injury) a pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for one of three sampled residents (Resident 2). These deficient practices resulted in inaccurate wound staging for Resident 2 and had the potential in a delay in care and services leading to a decline in Resident 2 ' s physical and psychosocial well-being. Findings: During a review of Resident 2's Admission Record (Face Sheet), the Face Sheet indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertensive heart failure (damage to heart due related to high blood pressure), muscle wasting (loss of muscle and strength) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/15/2024, the MDS indicated Resident 2 ' s cognitive skills for daily decision-making were impaired. The MDS indicated Resident 2 was at risk for developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries during the assessment period. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had one pressure ulcer/injury stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) during the assessment period. During a review of Resident 2's Skin and Wound Evaluation Form, dated 12/10/2024, the form indicated Resident 2 had Stage 4 pressure ulcer/injury on the left gluteus with an area measuring 1.3 centimeters (cm - unit of measurement) 2 (centimeters squared, a unit used in the measurement of area), 1.0 cm in length, 1. 3 cm wide, 1.4 cm deep, with undermining (pocket under wound surface). During a review of Resident 2's Skin Check Form, dated 12/16/2024, the form indicated Resident 2 had a pressure ulcer/injury stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible) on the left gluteus and left gluteal area. During an interview on 1/7/2025 at 12:52 p.m., with the Quality Assurance Nurse (QAN) stated on 10/14/2024 and 12/10/2024, Resident 2 was assessed with a stage 4 pressure ulcer/ injury. The QAN stated on 12/16/2024, the licensed nurse classified Resident 2 ' s wound as a stage 3, which was incorrect. The QAN nurse stated wounds cannot be reversed staged meaning the wound cannot be classified as a stage 3, when it was originally classified as a stage 4. The QAN stated wound classification must be accurate and consistent as it provides clinical information that direct needed assessments or treatments. (continued on next page)

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	01/07/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/7/2025, at 4:30. p.m., with the Director of Nursing (DON) stated wounds cannot be reverse staged to a lower level. The DON stated inaccurate assessment of wounds can lead to miscommunication between staff and physicians and lead to a delay in care and services. During a review of the facility ' s policy and procedure (P&P) titled, Wound Care Suggestion and Documentation, revised October 2021, the P&P indicated wounds will be staged in accordance with the National pressure ulcer Advisory Panel (NPUAP) guidelines. During a review of an online article titled, The Facts about Reverse staging in 2000 the National Pressure Ulcer Advisory Panel (NPUAP) Position statement, Retrieved 1/15/2025, from https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/position_statements/reverse-staging-position-sta.pdf, the article indicated, in 1989 due to a lack of research validated tools to measure pressure ulcer healing, clinical reported to using pressure ulcer staging systems in reverse order to describe improvement in an ulcer. The article indicated why not reverse stage? Pressures ulcers heal to progressively more shallow depth, they do not replace lost muscle, subcutaneous fat, or dermis before they epithelialize. The reverse staging does not accurately characterize what is physiologically occurring in the ulcer, once a stage 4 always a stage 4.