STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER: Sunnyside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on interview and record review, the facility failed to ensure one of three sampled resident ' s (Resident 1) responsible party ' s (RP 1) complaint ' s regarding Resident 1 ' s Activities of Daily Living (ADLs - activities such as bathing, dressing and toileting a person performs daily) care was formally logged as a grievance (complaint) and investigated as indicated in the facility ' s policy and procedures (P&P) titled, Grievances/Complaints, Filing. This deficient practice resulted in a violation of Resident 1 ' s RP rights and a potential delay in the care and delivery of services to Resident 1. Findings: During a review of Resident 1's Admission Record (Face Sheet), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (airways that carry air to lungs become narrow and damaged), tracheostomy status (a surgical procedure to create an opening through the neck into the windpipe that provides an air passage to help you breathe when the usual route for breathing is obstructed or impaired), and dependence on a ventilator (medical device that helps people breathe by moving air in and out of their lungs when they are unable to do so on their own). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 1 had severe cognitive impairment (ability to think, learn, remember, use judgement, and make decisions) and did not have the ability to understand or be understood by others. During a telephone interview on 3/10/2025 at 11:13 a.m., RP 1 stated she and her family had made multiple complaints regarding the lack of ADL care being provided to Resident 1. RP 1 stated when she and her family arrive in the morning to visit Resident 1, they have observed Resident 1 to be lying in soiled briefs and ungroomed. RP 1 stated she spoke with Registered Nurse (RN) 1 on multiple occasions during the last few weeks (February 2025 and March 2025) regarding her concerns but was not provided any resolution nor follow-up. RP 1 stated she was concerned that Resident 1 ' s pressure injuries were worsening due to a lack of care and feared the facility neglected Resident 1, which caused her to be transferred to a General Acute Care Hospital (GACH) on 3/6/2025. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/10/2025 at 1:30 p.m., the Social Services Director (SSD) stated all facility staff should follow the grievance process when there is a concern regarding lack of quality of care. The SSD stated any staff member can initiate a grievance but should notify the SSD department for the grievance to be directed to the appropriate department for investigation and resolution. The SSD stated the administrator is the facility ' s grievance officer and responsible to ensure timely follow up with the family or resident. The SSD stated by failing initiate a grievance, it could potentially lead to a lack of follow up with the family which cause worry and concern and is a violation of residents ' rights. During an interview on 3/10/2025 at 1:50 p.m., Registered Nurse (RN) 1 stated she was aware of Resident 1 ' s RP care concerns regarding Resident 1 not being provided regular ADL care. RN 1 stated she did not complete a grievance form nor notify the Social Services Department because she thought after talking to RP 1, RP 1 was satisfied. RN 1 stated, on several occasions over the last few weeks, RP 1 has expressed dissatisfaction with the care Resident 1 was receiving. RN 1 stated, she thought she had addressed all of RP 1 ' s concerns during their conversation however, after a few days, RP 1 has additional complaints and concerns. RN 1 stated she should have initiated the grievance process to ensure an interdisciplinary team meeting was held to address the concern and provide a consistent follow up with RP 1. During an interview on 3/10/2025 at 2:20 p.m., the Social Services Assistant (SSA) stated she is responsible for directly following up with grievances and complaints. SSA stated she was not notified by any staff members that Resident 1 ' s RP had complaints. SSA stated if she was made aware of the concerns, she could have assisted speaking with the RP1 to ensure her concerns were addressed and she understood the grievance process. During an interview on 3/11/2025 at 2 p.m., the Administrator stated he was not made aware of any concerns from Resident 1 ' s RP. The Administrator stated it is the policy of the facility to ensure all grievances are investigated and resolved to the understanding of the resident and or representative. The Administrator stated failure to ensure grievances are initiated, investigated and resolved can lead to potential delay in care for the resident and frustration and distrust in the family toward the facility. During a review of the facility ' s policy, and procedure (P&P) titled, Grievances/complaints, Filing, revised October 2024, the P&P indicated residents, and their representatives have the right to file grievances either orally or in writing to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolves grievances to the satisfaction of the resident and or representative. The P&P indicated any resident, family member or appointed representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, or any other concerns regarding his or her stay in the facility. Grievances also may be voiced or filed regarding care that has not been furnished. Upon receipt of the grievance, and or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) workings, days of receiving the grievance and or complaint. The resident or persons filing the grievance or complaint of behalf of the resident will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44958 Based on observation, interview and record review, the facility failed to conduct an Interdisciplinary Team ([IDT] health care professionals who work together with the resident to plan the residents plan of care) meeting timely for one of three sampled residents (Resident 1) and failed to ensure Resident 1 ' s Responsible Party (RP1) was given the opportunity to meet with the IDT regularly per the facility ' s policy and procedure (P&P) titled, Care plans, Comprehensive Person Centered. These deficient practices resulted in a violation of RP1 ' s rights and had the potential to delay person centered care interventions to Resident 1. Findings: During a review of Resident 1's Admission Record (Facesheet), indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure (airways that carry air to lungs become narrow and damaged), tracheostomy status (a surgical procedure to create an opening through the neck into the windpipe that provides an air passage to help you breathe when the usual route for breathing is obstructed or impaired), and dependence on a ventilator (medical device that helps people breathe by moving air in and out of their lungs when they are unable to do so on their own). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 1 had severe cognitive impairment (ability to think, learn, remember, use judgement, and make decisions) and did not have the ability to understand or be understood by others. During a telephone interview on 3/10/2025 at 11:13 a.m., RP 1 stated she and her family had made multiple complaints regarding the lack of Activities of Daily Living (ADLs - activities such as bathing, dressing and toileting a person performs daily) care being provided to Resident 1. RP 1 stated she has not been involved in an IDT meeting with the facility staff since sometime in 2024. RP 1 stated she has received updates on Resident 1 ' s care but has not been given the opportunity to discuss specific concerns regarding the status of Resident 1 ' s multiple pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence). RP 1 stated, it seems like Resident 1 ' s wounds get worse everytime she comes back to the facility from the General Acute Care Hospital (GACH), and she thought the facility was making Resident 1 ' s wounds worse. RP 1 stated she does not have a clear understanding of how the facility is caring for Resident 1 ' s wounds and she feels the facility has not provided her an opportunity to discuss her concerns and to provide answers to her questions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/11/2025 at 11 a.m., with the Director of Quality Assurance (QA) Nurse, Resident 1 ' s Skin Tears, Bruises and Other Injurie IDTs dated 1/7/2025, 1/18/2025, 2/6/2025 and 2/19/2025 were reviewed. The IDTs indicated RP 1 was not included in the IDT meetings. The QA Nurse stated, the records do not indicate RP 1 was in attendance during any of the IDT meeting nor provided an update on what was discussed. The QA Nurse stated the facility failed ensure the right of the resident or their representative to take care part in the care planning process. During a subsequent interview on 3/11/2025 at 11:15 a.m., the QA Nurse stated Resident 1 had multiple hospitalization s from September 2024 through March 2025. The QA Nurse stated based on her review of the Resident 1 ' s clinical records, the last IDT meeting the facility held with RP 1 was in 9/2024. The QA Nurse stated RP1 should have been provided an opportunity to take part in an IDT meeting after the hospitalization s. The QA Nurse stated the purpose of regular IDT meetings is to provide the resident and/or representative the opportunity to take part in planning the resident ' s care. The QA Nurse stated during an IDT meeting, multiple healthcare professionals from different departments are present for the resident and or resident ' s representative to address concerns and questions. The QA Nurse stated failure to conduct regular IDT meetings to discuss and update Resident 1 ' s plan of care can cause RP 1 to distrust the facility and had the potential to cause a delay in care and necessary services for Resident 1. During a review of the facility ' s P&P titled, Interdisciplinary Team Guidelines , Care Planning, revised 11/2016, the P&P indicated the IDT will allow the resident and or representative to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person centered plan of care. During a review of the facility ' s P&P titled, Care Plans, Comprehensive Person Centered, revised 9/2024, the P&P indicated the IDT in conjunction with the resident and her family, develops and implements a comprehensive/person-centered care plan for each resident, the IDT must review and update the care plan when the resident has been readmitted to the facility from a hospital stay and at least quarterly in conjunction with the required MDS assessment.