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	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Nursing Center	22617 S. 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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of three sampled residents (Resident 1) to address offloading (minimizing or removing weight placed on a bony prominence to help prevent and heal ulcers) while Resident 1 was up in the wheelchair daily. This deficient practice had the potential to contribute to the decline in Resident 1's unstageable (when the stage is not clear, the base of the wound is covered by a layer of dead tissue that may be yellow, grey, green, brown, or black) pressure injury (unrelieved pressure causes damage to the skin and underlying structures). 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 post laminectomy syndrome (failed back surgery syndrome which causes lingering pain), disease of the spinal cord, malignant neoplasm of the kidney (kidney cancer), and malignant neoplasm of the bone (bone tumor). During a review of Resident 1's history and physical (H&P) dated 5/17/2025, the H&P indicated Resident 1 was sent to the facility for physical therapy (PT - a rehabilitation profession that restores, maintains, and promotes optimal physical function) and occupational therapy (OT - rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities). The H&P indicated Resident 1 was experiencing weakness and a burning sensation in bilateral (both) lower extremities (legs). The H&P indicated Resident 1 was free from pressure injuries on the sacrococcyx area (a shield-shaped bony structure that is located at the base of the backbone). During a review of Resident 1's Skin check dated 5/17/2025, the Skin Check indicated Resident 1 had a wound on his mid back due to previous spine surgery. The Skin Check did not indicate there were any issues with the sacrococcyx area. During a review of Resident 1's Alert Note dated 5/21/2025, the note indicated changes to skin integrity were observed and Resident 1 had a stage two (a shallow open wound) coccyx pressure injury. (continued on next page)

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's minimum data set (MDS, a resident assessment tool) dated 5/23/2025, the MDS indicated Resident 1 was cognitively (relate to acquiring knowledge and understanding through thought, experience, and the senses) intact. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting and bathing. The MDS indicated Resident 1 was partial/ moderate assist (helper does less than half the effort) for rolling left to right and chair to bed transfers were not attempted during the review. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR- a concise communication tool, healthcare teams use to share information about the condition of a resident) Summary for Providers dated 5/27/2025, the SBAR indicated Resident 1's stage two pressure injury had deteriorated. The SBAR indicated the wound was noted with peeling skin, and multiple areas with skin gaps. The physician (MD 1) ordered a low air loss mattress (special bed to relive pressure). The SBAR indicated to encourage Resident 1 to turn and reposition every two hours. During a review of Resident 1's skin/ wound progress note dated 5/28/2025, the progress note indicated Resident 1's sacrococcyx pressure injury was now reclassified as an unstageable pressure injury. During an interview on 6/18/2025 at 12:25 p.m., Resident 1's family member (FM1) stated when Resident 1 was admitted to the facility he did not have any pressure injuries to the sacral area but when he left, he had a huge wound. FM 1 stated Resident 1 would visit with family sitting up in the wheelchair on the patio and staff would not come and change his position while he was sitting up in the wheelchair and sometimes, he would have no padding on the wheelchair while he was sitting in it. FM 1 stated after Resident 1 had surgery on his spine he could no longer feel his legs, so he needed help and to be reminded to change positions. During an interview on 6/20/2025 at 11:14 a.m., licensed vocational nurse (LVN) 1 stated Resident 1 would visit with his family daily on the patio in his wheelchair for an hour or two and FM 1 would sometimes bring a cushion for Resident 1 to sit on while he was visiting. During an interview on 6/20/2025 at 11:45 a.m., treatment nurse (TXN) 1 stated Resident 1 did not have any skin issues on the sacrococcyx area when he was admitted to the facility. TXN 1 stated she first noticed a very shallow stage 2 pressure injury in that area and then the edges deteriorated and were peeling with slough and the wound was reclassified as an unstageable pressure injury. TXN 1 stated Resident 1 was getting up into the wheelchair multiple times a day to visit with family. TXN 1 stated wounds could develop if residents sat up in wheelchairs (with no pressure relief interventions) for extended periods of time. During an interview on 6/20/2025 at 2:02 p.m., with LVN 2, LVN 2 stated he usually worked the 11 p.m. to 7 a.m. shift and he was never notified Resident 1 was refusing to be turned or repositioned. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/20/2025 at 2:42 p.m., with the unit Director of Nursing (DON), Resident 1's care plans were reviewed. The DON stated Resident 1 was mostly a bed bound patient that had no feeling in his lower body due to spinal surgery. The DON stated Resident 1 required assistance to do his daily routines. The DON stated she reviewed Resident 1's care plans and Resident 1 was to be turned and repositioned every 2 hours or more frequently if needed. The DON stated Resident 1 did not have a physician's order and a care plan with interventions to offload pressure on Resident 's Sacrococcyx area while in bed or a wheelchair. The DON stated care plans were important to guide the care of the residents and address how to prevent conditions from worsening. The DON stated if Resident 1 was refusing to be turned while sleeping, the care plan should have been updated to reflect his preferences During a review of the facility's policy and procedure (P/P) titled Wound Care Suggestions and Documentation dated 2/2025, the P/P indicated care plans were to be updated accordingly to reflect current interventions to prevent further breakdown as appropriate.

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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 0686 Level of Harm - 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** Based on interview and record review, the facility failed to prevent an avoidable, facility acquired, unstageable (when the stage is not clear, the base of the wound is covered by a layer of dead tissue that may be yellow, grey, green, brown, or black) pressure injury (damage to the skin and underlying structures caused by unrelieved pressure) for one of three sampled residents (Resident 1) by: 1. Failing to reposition Resident 1 every two hours as per physician's orders. 2. Failing to implement its Policy and Procedure (P&P) titled, Wound Care Suggestions and Documentation, dated 2/2025 which indicated Residents who were unable to turn independently would be turned and repositioned every two hours and would be checked for incontinence (loss of voluntary control of bowel and bladder movements) every two hours. As a result of these deficient practices, Resident 1 who was admitted to the facility on [DATE] with intact skin (no wounds) on the Sacrococcyx (area where sacrum [triangular bone at the base of the spine] and coccyx [tailbone] fuse together) area, developed an unstageable pressure injury to the sacrococcyx extending to bilateral (both) buttocks on 5/27/2025 (approximately 11 days after admission), that required evaluation and treatment at a general acute care hospital (GACH) on 6/8/2025. Resident 1's Sacrococcyx pressure injury was debrided (medical removal of dead, damaged, or infected tissue to improve the healing potential of the wound) and reclassified as a stage 4 pressure injury (the most severe stage of a pressure ulcer, characterized by extensive tissue damage extending to muscle, tendon, and sometimes even bone). 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, post laminectomy syndrome (failed back surgery syndrome which causes lingering pain), disease of the spinal cord, malignant neoplasm of the kidney (kidney cancer), and malignant neoplasm of the bone (bone tumor). During a review of Resident 1's history and physical (H&P) dated 5/17/2025, the H&P indicated Resident 1 was admitted to the facility for physical therapy (PT - a rehabilitation profession that restores, maintains, and promotes optimal physical function) and occupational therapy (OT - rehabilitative profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities). The H&P indicated Resident 1 had the capacity to make medical decisions. The H&P indicated Resident 1 was experiencing weakness and a burning sensation in bilateral lower extremities (legs). The H&P indicated Resident 1 was free from pressure injuries on the Sacrococcyx area. During a review of Resident 1's Skin Check dated 5/17/2025, the Skin Check indicated Resident 1 had a wound on his mid back due to previous spinal surgery. The Skin Check did not indicate there were any other skin issues including the sacrococcyx area. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's care plan focused on Resident has a callus (thick skin) to the Left Heel dated 5/17/2025, the care plan goal indicated Resident 1 would not have any complications and interventions included Resident 1 requiring assistance to turn and reposition at least every two hours or more often as needed or requested. During a review of Resident 1's skilled nursing facility (SNF)- Documentation Survey Report for May through June 2025, the SNF Documentation Survey Report indicated: Intervention/ Task turn reposition every 2 hours every shift. The SNF Documentation Survey Report indicated Resident 1 was not turned on the following occasions (N = No, not turned and repositioned): 1. 5/19/2025 (11p.m. to 7 p.m. shift) 2. 5/19/2025 (7 a.m. to 3 p.m. shift) 3. 5/20/2025 (11 p.m. to 7 a.m. shift) 4. 5/21/2025 (11 p.m. to 7 a.m. shift) 5. 5/23/2025 (3 p.m. to 11 p.m. shift) 6. 5/25/2025 (11 p.m. to 7 p.m. shift) 7. 5/26/2025 (11 p.m. to 7 p.m. shift) 8. 5/27/2025 (11 p.m. to 7 a.m. shift) 9. 5/29/2025 (3 p.m. to 11 p.m. shift) 10. 5/30/2025 (11 p.m. to 7 a.m. shift) 11. 5/31/2025 (11 p.m. to 7 a.m. shift) 12. 6/1/2025 (11 p.m. to 7 a.m. shift) 13. 6/4/2025 (3 p.m. to 11 p.m. shift) 14. 6/7/2025 (3 p.m. to 11 p.m. shift) During a review of Resident 1's Alert Note dated 5/21/2025, the note indicated Resident 1 had a coccyx pressure injury, stage two (a shallow open wound). During a review of Resident 1's Order Summary Report, the Order Summary report indicated an order was placed on 5/21/2025 to reposition Resident 1 every two hours. The Order Summary Report also indicated for Sacrococcyx pressure injury stage two; cleanse with normal saline, pat dry and apply triad paste (paste that creates a moist wound healing environment), leave open to air, every shift for 21 days. The Order Summary report indicated the order was discontinued on 5/27/2025. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's minimum data set (MDS, a resident assessment tool) dated 5/23/2025, the MDS indicated Resident 1 was cognitively (relate to acquiring knowledge and understanding through thought, experience, and the senses) intact. The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting and bathing. The MDS indicated Resident 1 was partial/ moderate assist (helper does less than half the effort) for rolling left to right and chair to bed transfers were not attempted during the MDS assessment. The MDS indicated Resident 1 was at risk for developing pressure injuries. During a review of Resident 1's Change of Condition (COC) Evaluation dated 5/27/2025, the COC indicated Resident 1's stage two pressure injury had deteriorated (became progressively worse). The COC indicated the wound was noted with peeling skin, and multiple areas with skin gaps. The COC indicated Resident 1's physician (MD 1) ordered a low air loss mattress (a special mattress designed to relieve pressure). The COC indicated Resident 1 would be encouraged to turn and reposition every two hours. During a review of Resident 1's Skin/ Wound Progress Note dated 5/28/2025, the Progress Note indicated Resident 1's sacrococcyx pressure injury had deteriorated and was reclassified as an unstageable pressure injury. During a review of Resident 1's Order Summary Report dated 5/28/2025, the Order Summary Report indicated Santyl Ointment (medication used to remove damaged tissue from pressure injuries) 250 units (a unit of measurement) per gram (GM, a unit of measurement) apply to the sacrococcyx topically (outside of body) each day shift for unstageable pressure injury. During a review of Resident 1's GACH Record titled, Wound Care Consult dated 6/8/2025, the Consult Note indicated Resident 1 was admitted to the GACH on 6/8/2025 with an unstageable sacrococcyx pressure ulcer extending to the bilateral buttocks. The consultation note indicated Resident 1's bone was palpable (abnormaly, able to be touched or felt) under the slough and the wound had a strong malodorous smell (indicating presence of an infection). The Consult Note indicated Resident 1 was to be seen by a surgeon for debridement. During a review of Resident 1's GACH Record titled, Surgery Consult/ H&P dated 6/8/2025, the H&P indicated Resident 1's sacrococcyx wound was debrided at the bedside and a wound culture (sample) was taken of the purulent (pus) drainage. During a review of Resident 1's GACH Record titled, Wound Care Consult- Follow Up dated 6/9/2025, the Consult Note indicated Resident 1's sacrococcyx pressure injury had deteriorated and was reclassified as stage 4 pressure injury after the debridement on 6/8/2025. During a review of Resident 1's GACH Record titled, Hospital Course dated 6/8/2025 to 6/16/2025, the GACH record indicated Resident 1 had a debridement on 6/8/2025 and 6/10/2025. The GACH record indicated the wound culture obtained on 6/8/2025 was positive for enterococcus faecalis (E. Faecalis, an opportunistic pathogen [an organism that causes disease] capable of causing severe infection) and there was unclear evidence of osteomyelitis (bone infection). The GACH record indicated Resident 1 was started on a two-week course of Zosyn (medication used to treat infection). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/18/2025 at 12:25 p.m., with Resident 1's family member (FM) 1, FM 1 stated Resident 1 was still at the GACH because Resident 1 developed a bad pressure injury right where the butt crack starts at the facility that became infected. FM 1 stated Resident 1 had extensive cancer of the kidney and the GACH informed her they were unable to start chemotherapy (powerful drugs to treat cancer) because of the infection of Resident 1's pressure injury. FM 1 stated when Resident 1 was admitted to the facility he did not have any pressure injuries but when he left the facility, he had a huge wound. FM 1 stated she or another family member visited Resident 1 daily. FM 1 stated for four or more hours staff never repositioned Resident 1 or checked if he was wet. FM 1 stated even when Resident 1 was sitting up in the wheelchair in the patio staff never repositioned him. FM 1 stated sometimes, Resident 1 did not have any padding (cushion to relieve pressure off his Sacrococcyx area) on the wheelchair while sitting in it. FM 1 stated after Resident 1 had surgery on his spine he could no longer feel his legs, so he needed help, and he needed to be reminded to change positions. During an interview on 6/18/2025 at 3:48 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to and cared for Resident 1 frequently during the 11 p.m. to 7 a.m. shift. CNA 1 stated Resident 1 was usually asleep from the beginning of her shift (11 p.m.) to about 4 a.m. to 5 a.m., and she did not turn and reposition him every two hours during that time because he (Resident 1) refused to be woken up. During an interview on 6/20/2025 at 11:45 a.m., with Treatment Nurse (TXN) 1, TXN 1 stated Resident 1 did not have any skin issues on the sacrococcyx area when he was admitted to the facility on [DATE]. TXN 1 stated on 5/21/2025 she (TXN 1) first noticed a very shallow stage 2 pressure injury in Resident 1's sacrococcyx area. TXN 1 stated the wound edges deteriorated and were peeling with slough and then the wound was reclassified as an unstageable pressure injury. TXN 1 stated Resident 1 was up in the wheelchair multiple times a day to visit family. TXN 1 stated wounds could develop if residents sat up in wheelchairs for extended periods of time, and the pressure on the bony areas was not relieved. TXN 1 stated Resident 1's legs were flaccid (weakness, loss of muscle tone, and loss of reflexes) when she provided wound treatments. TXN 1 stated if a resident refused to turn or reposition, the nursing staff should have made a care plan for noncompliance and wrote it in the progress notes. TXN 1 stated turning and repositioning was the number one intervention to prevent worsening of Resident 1's pressure injury. During an interview on 6/20/2025 at 2:02 p.m., with LVN 2, LVN 2 stated he usually worked the 11 p.m. to 7 a.m. shift and he was never notified Resident 1 was refusing to be turned or repositioned. During a concurrent interview and record review on 6/20/2025 at 2:42 p.m., with the unit Director of Nursing (DON), Resident 1's medical records were reviewed. The DON stated Resident 1 was mostly a bed bound patient that had no feeling in his lower body due to spinal surgery. The DON stated Resident 1 required assistance to do his daily routines. The DON stated turning and repositioning every 2 hours was important to keep pressure off the site and turning and repositioning every 2 hours as ordered had the potential to keep pressure sores from developing or worsening. The DON reviewed Resident 1's SNF- Documentation Survey Report for May through June 2025 and stated there were multiple days marked No for turning and repositioning, and each shift that was marked No indicated staff did not turn or reposition Resident 1 for the whole 8-hour shift. The DON stated residents were to be turned every two hours. The DON stated, per the documentation, Resident 1 was not turned and repositioned every two hours as ordered and there was no documentation in the chart to explain why. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P & P titled Wound Care Suggestions and Documentation dated 2/2025, the P& P indicated care plans were to be updated accordingly to reflect current interventions to prevent further breakdown as appropriate. The P& P indicated each wound a resident had, was to be documented upon admission. The P& P indicated if a resident was refusing care (e.g. refusing to turn), the education provided to the resident was to be documented in the chart. The P &P indicated unstageable pressure injuries; the true extent of the wound could not be determined until the slough was removed. The P/P indicated Residents who were unable to turn independently would be turned and repositioned every two hours and would be checked for incontinence every two hours.