

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 07/24/2025
NAME OF PROVIDER OR SUPPLIER Sunnyside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of two sampled residents (Resident 1) was free from neglect when staff did not provide timely incontinence care and left Resident 1 soiled with urine and feces, with a towel placed between his legs and failed to perform incontinent care. This failure compromised Resident 1's dignity and created potential for harm including risk for skin breakdown, and infection. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including cerebral infarction (blockage of blood flow to the brain, leading to tissue damage or death), malignant neoplasm of rectum (cells in the rectal lining grow uncontrollably and abnormally), and vascular dementia (conditions that damage blood vessels in the brain). During a review of Resident 1's History and Physical (H&P) dated 10/18/2024, the H&P indicated Resident 1 did not have the capacity to make decisions. During a review of Resident 1's Minimum Data Set ([MDS] resident assessment tool) dated 4/26/2025, indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) on toileting hygiene, shower/bath, and personal hygiene. The MDS indicated Resident 1 was always incontinent with urine and bowel movements and was at risk of developing pressure ulcers/injuries. During a concurrent observation and interview on 7/24/2025 at 8:20 a.m. with Certified Nurse Assistant (CNA 1), observed Resident 1 lying in bed on his right side, towel positioned on Resident 1's perineal area (skin between your [genitals]- external and internal reproductive organs), saturated with urine and feces. Resident 1 had dried feces on his buttocks and thighs. The odor of urine and feces was noticeable upon entering the room. CNA 1 stated that Resident 1 was dependent of care, and he had a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) on his left buttock and left thigh. CNA 1 stated residents should be checked every two hours and as needed to avoid them being left soiled for long periods of time, which could cause skin breakdown. CNA 1 stated neglect (the ongoing failure to meet a person's basic needs) would be not changing the residents in a timely matter, delaying care, and withholding care. CNA 1 stated if a resident goes for a long time without being change it could cause pressure ulcers, or they could develop a urinary tract infection ([UTI]- an infection in any part of the urinary system) due to the bacteria (germs that cause infection) from the feces and urine. CNA 1 stated that it was not the facility's practice to use towels for residents' perineal area. CNA 1 stated that Resident 1 should not have a towel placed in his perineal area, because that could cause skin problems because the towel was rough on the skin. CNA 1 stated Resident 1 could have felt neglected due to being left lying in feces and urine. CNA 1 validated the feces observed on Resident 1 was dry which indicates that he had not been cleaned in a timely manner and that would be consider neglect. During a concurrent interview and record review on 7/24/2025 at 10:24 a.m. with the Treatment Nurse (TN 1), Resident 1's Change of Condition (COC), dated July 2025 was reviewed. The COC indicated, on 7/2/2025, Resident was noted by TX Nurse with an open wound to the left hip. Wound Measurement 3.0 centimeter (cm-unit of measurement) by 4.0 cm. Light serious drainage noted, No mal odor, no signs and symptoms of infection. TN 1 stated Resident 1 was dependent on care for repositioning, toileting and hygiene care. TN 1 stated Resident 1 had a healed pressure ulcer on his left buttock upon admission on [DATE]. TN 1 stated the reopening of the left buttock pressure ulcer was identified on 7/2/2025 by the TN 2. TN 1 stated incontinence management (the management and treatment of involuntary loss of bladder or bowel control) was important in order to maintain resident's dignity and prevent health complications. TN 1 stated that incontinence management helps to prevent pressure ulcers, prevent worsening of current pressure ulcers, and to prevent a reopening of a healed pressure ulcer. TN 1 stated towels were not a standard of practice at the facility, and should not be used as a diaper, because they are rough and can cause friction. TN 1 stated using towels on Resident 1's perineal area could have caused his healed pressure ulcer to reopen. TN 1 stated he had received training on neglect and that not cleaning Resident 1 in a timely manner would be considered neglect. TN 1 stated if residents are not cleaned in a timely manner the residents could develop skin breakdowns such as pressure ulcers and could cause a healed pressure ulcer to reopen. TN 1 stated that residents being left soiled with urine and feces could also cause the residents to develop a urinary tract infection (UTI) due to the bacteria. During an interview on 7/24/2025 at 11:55 a.m. with the Director of Nursing (DON) the DON stated that the facility's practice was to</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including cerebral infarction (blockage of blood flow to the brain, leading to tissue damage or death), malignant neoplasm of rectum (cells in the rectal lining grow uncontrollably and abnormally), and vascular dementia (conditions that damage blood vessels in the brain). During a review of Resident 1's History and Physical (H& P) dated 10/18/2024, the H&P indicated Resident 1 did not have the capacity to make decisions. During a review of Resident 1's Minimum Data Set ([MDS] resident assessment tool) dated 4/26/2025, indicated Resident 1 was dependent (helper does all of the effort, resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) on toileting hygiene, shower/bath, and personal hygiene. 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