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	09/10/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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

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	09/10/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 9), whose preference to have a shower instead of a bed bath, was honored. This deficient practice resulted in Resident 9 receiving bed baths on multiple occasions when his preference was to have a shower. This deficient practice had the potential for Resident 9 to feel disrespected and uncomfortable during his stay at the facility. Findings: During a review of Resident 9's admission Record (Face Sheet), the Face Sheet indicated Resident 9 was admitted to the facility on [DATE] with a diagnosis of orthopedic aftercare (ongoing care and treatment after a bone, joint, or muscle procedure to help with proper healing, regain strength and movement) following a left leg below the knee amputation ([BKA] a surgical removal of the portion of the leg below the knee. During a review of Resident 9's Minimum Data Set ([MDS] a resident assessment tool) dated 7/21/2025, the MDS indicated Resident 9 was able to make decisions that were reasonable and consistent. The MDS indicated Resident 9 required a one person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) and he was incontinent (loss of full control) of his bladder. The MDS indicated it was very important for Resident 9 to choose between a bed bath or shower. During a review of Resident 9's Documentation and Survey Report dated 7/2025, the Documentation and Survey Report indicated Resident 9's Bathing Task from 7/14/2025 to 7/30/2025 indicated the following: a. Resident 9 was provided with a shower two times. b. Resident 9 refused a bath six times. c. There were fifteen shifts left blank without documentation that a bath or shower were provided to Resident 9. During a telephone interview on 8/29/2025 at 8:57 a.m., Resident 9 stated when he was at the facility he was only given two showers and there were multiple times he requested a shower but was given a bed bath. Resident 9 stated after he tested positive for COVID -19 (a potentially severe respiratory illness caused by a coronavirus and characterized by fever, coughing, and shortness of breath), the nursing staff tried to give him a shower, but he refused because he did not feel well. Resident 9 stated there were times following his COVID -19 diagnoses that the nursing staff did not give him a shower when he asked for one and there were times, he refused care because the nursing staff insisted on giving him a bed bath and he wanted a shower. During an interview on 9/3/2025 at 2:07 p.m., Certified Nursing Assistant (CNA) 2 stated Resident 9 was able to make his needs known and although he had periods of refusing his medications, he was particular with his care, especially his showers. CNA 2 stated residents' can make decisions regarding their care and the nursing staff should try to accommodate them. During an interview on 9/4/2025 at 12:03 p.m., the Senior Nurse Executive (SNE) stated it was important for residents' preferences to be honored to ensure their comfort and satisfaction. During an interview on 9/10/2025 at 11:08 a.m., the Chief Clinical Officer (CCO) stated accommodation of residents' needs and preferences was to ensure the residents' have a good quality of life. During a review of the facility's Policy and Procedure (P/P) titled, Quality of Life-Dignity revised 11/6/2024, the P/P indicated the facility shall provide each resident the care in a manner that promotes and enhances quality of life, dignity, respect, and individuality while honoring resident rights 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	09/10/2025

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. (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	09/10/2025

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a care plan was created to include a Fall Management Program for one of two sampled residents (Resident 16), who was assessed at high risk for falls, per the facility's policy and procedure (P/P). This deficient practice resulted in the care needs for Resident 16 not being thoroughly addressed and placed Resident 16 at risk for falls and injuries. Findings: During a review of Resident 16's admission Record (Face Sheet), the Face Sheet indicated Resident 9 was admitted to the facility on [DATE] with diagnosis including cerebral infarction ([stroke] loss of blood flow to a part of the brain) with left side hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 16's Minimum Data Set ([MDS] a resident assessment tool) dated 8/4/2025, the MDS indicated Resident 16 was able to make decisions that were reasonable and consistent and she required a one person assist to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) During a review of Resident 16's Nursing Morse Fall Scale dated 7/28/2025 and timed at 6 p.m., the Nursing Morse Fall Scale indicated Resident 16's Fall Risk Score was 65 (45 and higher score indicated a high risk for falls). The Nursing Morse Fall Scale indicated Resident 16 overestimated or forget her limits, was weak, had multiple medical diagnosis, and had a history of falls. During a review of Resident 16's Interdisciplinary Team Conference ([IDT] a group of healthcare professionals from different disciplines who work together to plan, coordinate and deliver comprehensive person-centered care to a resident) Record dated 8/4/2025 and timed at 8:19 a.m., the IDT Team Conference Record indicated Resident 16 was a high risk for falls due to weakness on the left side of her body, she was unable to care for herself and needed services to assist with her current condition and other chronic illnesses. During a review of Resident 16's untitled Care Plan, dated 7/28/2025, the Care Plan indicated Resident 16 had an increased risk of falls. The Care Plan's goal was for Resident 16 to understand the importance of seeking assistance to help reduce the risk of falls. The Care Plan's interventions included attempting to anticipate and meet Resident 16's needs and to encourage Resident 16 to use the call light for assistance. Continued review of the Care Plan indicated there was no documentation to indicate a Fall Management Program was included. During an interview on 9/5/2025 at 11:10 a.m., the Senior Nurse executive (SNE) stated, Resident 16 was identified as a high risk for falls upon admission, and the Falling Star Program should have been incorporated in her Care Plan, which included a low bed, fall pad, placing a star on her door, head of the bed and armband. During an interview on 9/10/2025 at 11:08 a.m., the Chief Clinical Officer (CCO) stated it was the responsibility of the IDT to create a comprehensive care plan for residents' at high risk for falls and to ensure the facility's Fall Management Program was included as part of the interventions to minimize, if not prevent, a fall and/or an injury. During a review of the facility's P/P titled, Care Plans-Comprehensive Person Centered revised 10/2/2024, the P/P indicated the Interdisciplinary Team of the facility shall manage and assist in formulating and implementing the residents' comprehensive person-centered care plan to ensure the objectives and timetables are measurable in order to meet the residents' physical, psychological and functional needs. During a review of the facility's undated, P/P titled, Risk Score Fall Prevention Protocol the P/P indicated the Morse Fall Scale was implemented by the facility to guide the care of the residents who are at risk for falls. The P/P indicated the residents who are medium to high risk for fall (with multiple risk factors and those who have fallen) will have interventions implemented to reduce the risk and severity of injuries due to falls as well as prevent falls from recurring, while supplementing fall prevention interventions. During a review of the facility's P/P titled, Falling Star Program updated 4/11/2016, P/P indicated the Falling Star Program is a facility-wide effort to reduce the incidence of falls among residents through increasing staff awareness of residents high risk for fall. The P/P indicated the facility assesses the resident for fall risk upon admission, quarterly and when a significant change of condition occurs and a plan of care is developed based on this assessment. The P/P indicated a resident found to be at risk for falls or repeated falls as per Interdisciplinary Team Assessment will be placed on the Falling Star Program and if the resident is appropriate for Falling Star Program, the care plan will be updated with the following interventions but not limited to:a. low bedb. landing padc. colored wrist band; and ad. star magnet by the door of the resident room.

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	09/10/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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	09/10/2025

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 10), who was admitted to the facility from a General Acute Care Hospital (GACH) on [DATE], was not administered Baclofen (a medication that relaxes the muscles to relieve spasm, tightness, and cramps) due to a known side effect of confusion, when: 1. Registered Nurse (RN) 1 did not review Resident 10's entire Discharge Instructions dated [DATE] and [DATE] for accuracy, prior to transcribing the orders in Resident 10's chart. 2. RN 1 did not review and clarify conflicting instructions outlined in the GACH's Discharge Instructions dated [DATE] which indicated do not use Baclofen since caused confusion versus the Discharge instructions dated [DATE], which indicated Medications to Continue to Take with no Change which indicated Baclofen 10 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) give 0.5 tablet three times daily, with Resident 10's physician. 3. RN 1 administered 5 doses of Baclofen 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) to Resident 10 without reconciling the orders with Resident 10's physician. 4. RN 1 did not follow the facility's Policy and Procedure (P/P), titled, Medication Orders Non-Controlled Medication Order Documentation revised 8/20219, which indicated nurses are to verify the GACH's order with attending physician before medication (Baclofen) was transcribed for administration. These deficient practices resulted in Resident 10 receiving Baclofen 5 mg from [DATE] through [DATE] (a total of six doses), experiencing shortness of breath (SOB), elevated blood pressure (BP), generalized weakness and increased confusion. Resident 10 was transferred to a GACH, where he was diagnosed with acute toxic encephalopathy (a condition characterized by sudden and severe brain dysfunction caused by exposure to toxic substances) and was dialyzed (treatment to remove waste products and excess fluid from the blood when the kidneys are unable to do so). On [DATE] at 3:28 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), the Interim Chief Clinical Officer (CCO) and the Senior Nurse Executive (SNE) due to the facility's failure to recognize a discrepancy in the GACH's discharge instructions and follow up with Resident 10's attending physician to clarify discharge/transfer orders prior to transcribing Baclofen for administration to Resident 10. On [DATE], the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on [DATE] at 3:40 p.m., in the presence of the facility's DON and ADM. The facility's IJRP included the following immediate actions: 1. On [DATE], Resident 10 was discharged to a GACH and was readmitted to the facility on [DATE] the admitting nurse verified the admissions orders with the attending physician. A medication error report for Baclofen was completed on [DATE] for the [DATE] admission orders and was reported to the attending physician and Resident 10's family. Resident 10 was discharged home on [DATE]. 2. On [DATE] the Interim Chief Clinical Officer (CCO)/ Designee provided a 1:1 (a personalized, process where an experienced person works directly with a learner to teach a specific task, process, or skill) in-service training to RN 1 on reviewing discharge orders, reconciling and verifying orders with attending physicians prior to carrying out the orders, the facility's P/P titled, Medication Orders Non-Controlled Medication Order Documentation which requires the licensed nurses to verify the GACH's order with attending physician before medications (Baclofen) are transcribed for administration. 3. On [DATE], a random audit of all in-house patients was completed by Health Information Manager (HIM) and the Interim CCO/designee. A total of 12 residents who were receiving Baclofen were identified and there were no concerns. On [DATE], a random audit of all newly admitted residents in the past 24 hours was conducted by the HIM and Interim CCO/designee. A total of 10 residents identified and their physicians 'orders were reviewed, reconciled with their attending physicians, no concerns were found. 4. On [DATE] the DSD/ Clinical Trainer provided re-training beginning to licensed nurses on entering orders into Electronic Treatment Administration Record ([eMAR/eTAR]) prior/pending confirmation, reconciliation and verification of orders. Licensed Nurses who are on leave, vacation, out sick or newly hired nurses will be educated prior to the start of their shift. 5. On [DATE], the DSD and the Clinical Trainer conducted an in-service training for licensed nursing staff on the facility's P/P titled, Medication Orders Non-Controlled Medication Order Documentation which requires the licensed nurses to verify the GACH's order with attending physician

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	09/10/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. (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	09/10/2025

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a QAPI (Quality Assurance/Quality Assurance and Performance Improvement - a data driven proactive approach to improvement used to ensure services are meeting quality standards) plan was implemented after being made aware of a deficient practice and failure of the facility, when one of three sampled residents (Resident 10), who was admitted to the facility from a General Acute Care Hospital (GACH) on 8/15/2025, was administered Baclofen (a medication that relaxes the muscles to relieve spasm, tightness, and cramps) with a known side effect of confusion, when: 1. Registered Nurse (RN) 1 did not review Resident 10's entire Discharge Instructions dated 8/14/2025 and 8/15/2025 for accuracy, prior to transcribing the orders in Resident 10's chart. 2. RN 1 did not review and clarify conflicting instructions outlined in the GACH's Discharge Instructions dated 8/14/2025 which indicated do not use Baclofen since caused confusion versus the Discharge instructions dated 8/15/2025, which indicated Medications to Continue to Take with no Change which indicated Baclofen 10 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) give 0.5 tablet three times daily, with Resident 10's physician. 3. Resident 10 was administered 5 doses of Baclofen without clarifying with her physician. 4. RN 1 did not follow the facility's Policy and Procedure (P/P), titled, Medication Orders Non-Controlled Medication Order Documentation revised 8/20219, which indicated nurses are to verify the GACH's order with attending physician before medication (Baclofen) was transcribed for administration. These deficient practices resulted in Resident 10 receiving Baclofen 5 mg from 8/15/2025 through 8/17/2025 (a total of six doses), experiencing shortness of breath (SOB), elevated blood pressure (BP), generalized weakness and increased confusion. Resident 10 was transferred to a GACH, where he was diagnosed with acute toxic encephalopathy (a condition characterized by sudden and severe brain dysfunction caused by exposure to toxic substances) and was dialyzed (treatment to remove waste products and excess fluid from the blood when the kidneys are unable to do so). See F684Findings: On 9/9/2025 at 3:28 p.m., an Immediate Jeopardy ([IJ] a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Administrator (ADM), the Interim Chief Clinical Officer (CCO) and the Senior Nurse Executive (SNE) due to the facility's failure to recognize a discrepancy in the GACH's discharge instructions and follow up with Resident 10's attending physician to clarify orders prior to transcribing Baclofen for administration to Resident 10. On 9/10/2025, the facility submitted an acceptable IJ Removal Plan ([IJRP] interventions to immediately correct the deficient practices). After onsite verification of the facility's IJRP's implementation through observation, interview, and record review, the IJ was removed on 9/10/2025 at 3:40 p.m., in the presence of the facility's DON and ADM. Findings: During an interview on 9/9/2025 at 120 p.m., the Medical Director stated as far as he was not aware that a QAPI meeting had been conducted related to Resident 10's Baclofen administration but stated one should have been conducted so there was awareness and education started for the all licensed nurses. During an interview on 9/10/2025 at 11 a.m., the Chief Clinical Officer (CCO) stated she did not complete an incident report related to Resident 10's medication error and she did not meet with the QAPI members, and she should have met with them The CCO stated it was important for the facility to conduct a QAPI meeting immediately after they were made aware of the deficient practice in order to address any concerns, find the root cause, develop and implement interventions to ensure the same incident did not happen again. During an interview on 9/10/2025 at 12:33 p. m., the Administrator (ADM) stated he was informed of the grievance from the family, which the CCO met with Resident 10's family and investigated but there was no incident report filed and there was no QAPI meeting conducted after the facility identified the deficient practice related to Resident 10's medication error. During a review of the facility's Policy and Procedure (P/P) titled, Quality Assurance Performance Improvement revised 11/9/2021, the P/P indicated . the facility should ensure the correction of quality deficiencies components to include: a. Tracking and measure performance b. Establishing goals and thresholds for performance measurement c. Systematically analyzing the underlying causes of systemic quality deficiencies d. Developing and implementing corrective action or performance improvement activities to include methods to validate and update the staff competencies at the time of hire and periodically or as needed; and e. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.