

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  10/22/2025
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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to implement its abuse prevention policy by failing to report suspected abuse to the State Survey Agency within 2 hours after the allegation for one of three sampled residents (Resident 1). As a result of this deficient practice, facility residents including Resident 1 were placed at risk for potential continued abuse, injuries, psychosocial harm and delay in care and investigation. 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 acute kidney failure (a condition in which the kidneys no longer function normally) and chronic heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, was independent when eating, required moderate assistance (helper does less than half the effort) for oral hygiene and upper body dressing, required maximal assistance (helper does more than half the effort) for toileting and bathing, and was dependent (helper does all the effort) for lower body dressing. During a record review on 10/22/2025 at 11:04 a.m. of Resident 1's nursing progress note dated 10/20/2025, the nursing progress note indicated RP informed LVN 1 that a male CNA (MCNA) roughly handled d Resident 1 during the 11 p.m. to 7 a.m. shift. The progress note indicated LVN 1 did not inform the RN Supervisor and advised the RP to follow up with management on Monday, 10/20/2025. During an interview on 10/22/2025 at 8:26 a.m. with Resident 1's Responsible Party (RP), the RP stated on 10/19/2025 at approximately 11:30 a.m., the RP reported to Licensed Vocational Nurse (LVN) 1, that Resident 1 stated on 10/18/2025 at approximately 1 a.m., a male MCNA pinned down and forcefully turned Resident 1 in the resident's room. The RP stated LVN 1 responded that the situation will be reported. The RP stated no one followed up with her on 10/19/2025. The RP stated she reported the allegation to the Registered Nurse (RN) Supervisor and the Administrator on 10/20/2025 at approximately 11 a.m. During an interview on 10/22/2025 at 11:42 a.m., with Licensed Vocational Nurse (LVN 2), LVN 2 stated rough handling was considered abuse and allegations of rough handling should be reported to the abuse coordinator and investigated. LVN 2 stated abuse reporting should be reported right away and not wait until the next business day to prevent any possible additional abuse from occurring. During an interview on 10/22/2025 at 12:07 p.m., with CNA 3, CNA 3 stated on 10/19/2025, RP told her that MCNA touched Resident 1 inappropriately when changing her the night before. CNA 3 stated they reported the situation to LVN 1 immediately. During an interview on 10/22/2025 at 12:47 p.m. with Registered Nurse (RN) 2, RN 2 stated rough handling should be treated as an abuse allegation and should be investigated. RN 2 stated resident should not be handled roughly. RN 2 stated abuse allegations should be reported to the abuse coordinator immediately even after business hours or on the weekend. During an interview on 10/22/2025 at 1:07 p.m., with LVN 1, LVN 1 stated on 10/19/2025 at approximately 1 p.m., the RP told LVN 1 that MCNA inappropriately rough handled Resident 1 on the 10/18/2025 11 p.m. to 7 a.m. shift. LVN 1 stated the Director of Nursing (DON) and the Administrator would not have picked up the phone due to the time of night. LVN 1 stated she entered a note for no male CNA's to care for Resident 1, since there is no one here to resolve the issue on a Sunday. During an interview on 10/22/2025 at 3:45 p.m. with the Administrator, the administrator stated allegations of rough handling should be investigated as abuse. The administrator stated that abuse allegations should be reported immediately, but no later than two hours after to the California Department of Public Health (CDPH- state survey agency), the ombudsman (a resident advocate), and the police department. The Administrator stated he was the abuse coordinator and the staff were instructed to report all abuse allegations to the abuse coordinator. The Administrator stated he the RP informed him of the abuse allegation that occurred on 10/19/2021 during the 11 p.m. to 7 a.m. shift on 10/20/2025 at approximately 11 a.m. and he faxed the report to CDPH on 10/20/2025 at 5:15 p.m. (approximately 6 hours after finding out of the allegation). The Administrator stated MCNA was placed on suspension on 10/20/2025. The Administrator stated it was important to report alleged abuse within two hours to protect the resident and investigate timely. During an interview with the Chief Clinical Officer (CCO), the CCO stated LVN 1 was aware of the rough handling on 10/19/2025, and did not report the alleged abuse on 10/19/2025. The CCO stated the alleged abuse should have been reported within two hours on 10/19/2025. The CCO stated it is important to report alleged abuse within two hours to ensure the facility takes proper precautions to maintain</p>		