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	12/05/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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 0557 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 residents (Resident 1) was free from rough handling and treated with dignity and respect, while being assisted by Certified Nurse Assistant (CNA) 1. This deficient practice resulted in a purplish discoloration to the left thumb, emotional distress, and loss of dignity and trust in staff. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including multiple fractures (broken bones) of the ribs (right side), and motor vehicle accident (car accident). During a review of Resident 1's History and Physical (H& P) dated 9/19/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS]resident assessment tool) dated 9/14/2025, the MDS indicated Resident 1 had normal cognitive function and required dependent (helper does all the effort) with toileting and personal hygiene.During an interview on 12/4/2025 at 8:30 a.m. with Resident 1, Resident 1 stated on the morning of the incident on 11/19/2025 at approximately 10:00 a.m., CNA 1 appeared to be in a bad mood and had informed her that she would be receiving a shower that morning. Resident 1 stated she told CNA 1 that she prefers to be showered between 3:00 p.m. and 11:00 p.m., not in the morning. Resident 1 stated that CNA 1 responded, Why didn't you tell me that earlier? Resident 1 stated that this conversation occurred at approximately 10:30 a.m. Resident 1 stated that after the shower, CNA 1 left her in the wheelchair for approximately 30 minutes and told her that she was going to lunch. Resident 1 stated that after lunch she did not want to call for CNA 1 due to the CNA's earlier behavior. Resident 1 stated that she believed CNA 1 was upset because she had worked a double shift and appeared to be rushed. Resident 1 stated that CNA 1 came to her room between approximately 6:00 p.m. and 7:00 p.m. to bring her dinner. Resident 1 stated that she told CNA 1 at that time that she intended to report her concerns to a supervisor. Resident 1 stated while CNA 1 was trying to put her gown on she took her left hand and squeezed it very hard. Resident 1 stated she had informed CNA 1 to be careful with her left arm, explaining that she had previously been in an accident and fractured it. Resident 1 stated during the provision of care, she told CNA 1 that the CNA was handling her too roughly. Resident 1 stated that after she voiced her concern, CNA 1 did not respond and continued with care. Resident 1 stated that she later reported to the RN Supervisor, (RNS) that CNA 1 had not returned to her room and had left her bedside table a mess, without cleaning the area after care. Resident 1 stated she did not inform the RNS at that time about CNA 1 squeezing her left hand because she was afraid to report it. Resident 1 stated that on 11/20/2025, she noticed purplish discoloration on her left thumb. Resident 1 stated that she informed License Vocational Nurse (LVN) 1 and asked her to come into the room to look at the discoloration. Resident 1 stated at that time, she told LVN 1 that the injury probably happened when CNA 1 squeezed my hand while changing my gown the previous day. Resident 1 stated that during her care, she observed CNA 1 appearing overwhelmed. Resident 1 stated that she believed this may have been because CNA 1 was working a double shift that day. Resident 1 stated that CNA 1 appeared to be rushing while providing the shower, which made her feel concerned about her care. Resident 1 stated that from the time she received her shower in the morning until the evening, when CNA 1 came in to bring her dinner tray, she did not call for assistance from CNA 1. Resident 1 stated that she chose not to call for help from the morning shower due to fear and concern regarding the CNA's earlier behavior. During an interview on 12/4/2025 at 8:45 a.m. with Resident 2, Resident 2 stated she heard Resident 1 telling CNA 1 that she was not handling her right. Resident 2 stated that the voices sounded loud, but she was unable to make out the full conversation between Resident 1 and CNA 1. During a telephone interview on 12/4/2025 at 9:33 a.m. with CNA 1, CNA 1 stated that on the day of the incident, she transferred Resident 1 into the shower chair, and after the transfer, Resident 1 informed her that she prefers to receive showers after 3:00 p.m. CNA 1 stated that the alleged incident occurred later in the evening when she was assisting Resident 1 with putting on her gown. CNA 1 stated that Resident 1 told her to be careful with her left arm prior to assistance, stating that she had a previous car accident which had fractured her left arm, and that lifting it too high could cause pain. CNA 1 stated that when she first attempted to lift the resident's arm, Resident 1 complained of pain, and CNA 1 immediately stopped. CNA 1 stated that she felt rushed during her interaction while showering the resident because she took a long time to shower and she needed to return to her other assigned residents. CNA 1 acknowledged that her feeling rushed may have contributed to handling Resident 1's left hand in a way that caused discomfort. CNA 1 stated that she