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	05/05/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure comprehensive person-centered Care Plans were reviewed and revised by the Interdisciplinary Team ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) when a resident (Resident 5) refused care for one of four sampled residents (Resident 5). This deficient practice had the potential for Resident 5's care needs and preferences to be unidentified and Resident 5 to continue refusing care which could negatively affect her quality of life and well-being.Findings:During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5 had diagnoses including cerebral infarction ([stroke] loss of blood flow to a part of the brain) with hemiplegia (total paralysis of the arm, leg, trunk on the same side of the body), hemiparesis (a slight paralysis or weakness on one side of the body), and lack of coordination.During a review of Resident 5's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 5 was able to make decisions that were reasonable and consistent and required two-person assist to complete her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) such as bathing, toileting hygiene, personal hygiene and transferring from chair/bed-to-chair. The MDS indicated Resident 5 was incontinent (loss of control) of bladder and bowel function.During a review of Resident 5's untitled Care Plan dated 7/21/2025, the Care Plan indicated Resident 5 had a self-care performance deficit. The Care Plan's goal indicated Resident 5 was to attain her highest functional mobility and ADLs. The Care Plan's interventions included providing Resident 5 with assistance with bathing, showering, dressing, oral care, personal hygiene, toileting hygiene and cleaning and/or trimming of fingernails during bath days and as necessary.During a review of Resident 5's untitled Care Plan dated 8/13/2025 and revised 1/23/2026, the Care Plan indicated Resident 5 refused incontinence care (brief changes) and trimming of fingernails. The Care Plan's goal indicated Resident 5 was to comply with changing of soiled briefs. The Care Plan's interventions included Resident 5 would comply with a brief change provided by the Certified Nursing Assistant (CNA).During a review of Resident 5's IDT Records, the IDT Records did not indicate Resident 5's refusal of incontinence care and fingernail trimming were discussed, and options of care preferences and/or accommodations were identified and explored by the facility team with Resident 5 or her Responsible Party (RP). The IDT Records did not indicate Resident 5 plan of care was re-evaluated and there was no recommendation and/or plan to revise and/or update the Care Plan's interventions.During an interview on 5/1/2026 at 2:22 p.m., CNA 1 stated Resident 5 refused to be changed at the start of the shift (7 a.m.), and he did not return to check on Resident 5 because he knew Resident 5 refuses care. CNA 1 stated there were no further instructions on what he needed to do when Resident 5 refused care.During an interview on 5/4/2026 at 11:35 a.m., Licensed Vocational Nurse (LVN) 3 stated there were times Resident 5 refused her fingernails to be cleaned and trimmed but she just needed to go back later during the shift to provide the care to Resident 5. During a subsequent review of Resident 5's plan of care, LVN 3 stated and confirmed Resident 5 had been identified to refuse incontinence (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	05/05/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care and fingernail trimming since 8/13/2025 but the Care Plan interventions were not revised or updated. LVN 1 stated the intervention should have been revised by identifying Resident 5's care preferences and accommodating them to gain her cooperation and offering the care not just once, but multiple times during the shift.During an interview on 5/4/2026 at 12:58 p.m., the Senior Nurse Executive (SNE) stated the facility IDT should have identified Resident 5's care preferences with Resident 5 and her Responsible Party and revised and updated the Care Plan interventions accordingly. The SNE stated the residents' plan of care shall be revised and updated as needed to ensure the interventions are unique and resident-centered.During a review of the facility's policy and procedure (P&P) titled, Care Planning-Interdisciplinary Team, revised 10/2024, the P&P indicated the IDT is responsible for the development of an individualized comprehensive care plan for each resident. The P&P indicated the residents' comprehensive care plan will be developed by the facility's interdisciplinary team.During a review of the facility's P&P titled, Care Plans-Comprehensive Person Centered, revised 10/2/2024, the P&P indicated the facility shall implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The P&P indicated the assessments of the residents are ongoing and the care plan are revised as information about the residents and the residents' condition change.

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	05/05/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 5), who required two-person assistance from staff to perform her activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily), that those ADLs were performed in a timely manner. This deficient practice had resulted in Resident 5 feeling neglected and had the potential to negatively impact her dignity and quality of life.Findings: During a review of Resident 5's admission Record (Face Sheet), the Face Sheet indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5 had diagnoses including cerebral infarction ([stroke] loss of blood flow to a part of the brain) with hemiplegia (total paralysis of the arm, leg, trunk on the same side of the body), hemiparesis (a slight paralysis or weakness on one side of the body), and lack of coordination. During a review of Resident 5's Minimum Data Set ([MDS] a resident assessment tool) dated 4/11/2026, the MDS indicated Resident 5 was able to make decisions that were reasonable and consistent and required two-person assistance from staff to complete her ADLs such as bathing, toileting hygiene, personal hygiene and transferring from chair/bed-to-chair. The MDS indicated Resident 5 and was incontinent (loss of control) of bladder and bowel function. During a review of Resident 5's untitled Care Plan dated 7/4/2025, the Care Plan indicated Resident 5 had limited physical mobility. The Care Plan's goal indicated Resident 5 was to maintain the current level of mobility. The Care Plan's interventions included assisting Resident 5 with bed mobility, turning and repositioning and transferring Resident 5 from bed to chair and chair to bed. During a review of Resident 5's untitled Care Plan dated 7/21/2025, the Care Plan indicated Resident 5 had a self-care performance deficit. The Care Plan's goal indicated Resident 5 was to attain her highest functional mobility and ADLs. The Care Plan's interventions included providing Resident 5 with assistance with bathing, showering, dressing, oral care, personal hygiene, toileting hygiene and cleaning and/or trimming of fingernails during bath days and as necessary. During a review of Resident 5's untitled Care Plan dated 7/21/2025, the Care Plan indicated Resident 5 had bowel and bladder incontinence. The Care Plan's goal indicated Resident 5 will be checked for incontinence and be changed. The Care Plan's interventions include providing Resident 5 with incontinent care and peri care after each incontinence episode, observing and documenting any signs or symptoms of infection, monitoring Resident 5's skin for redness or breakdown and report changes immediately, and performing all care in a manner that maintains Resident 5's dignity and respect. During a review of Resident 5's Interdisciplinary Team Conference Record ([IDT] a group of medical professionals from different disciplines who work together to help a resident achieve their goals) dated 4/16/2026, the IDT indicated Resident 5 was identified to have self-care and mobility deficits. The IDT indicated the goal of the plan of care was to prevent functional decline through ongoing care planning, with emphasis on maintaining quality of life, sustaining functional capabilities, and preserving Resident 5's dignity and privacy. During a concurrent observation and interview on 5/1/2026 at 2:12 p.m., in Resident 5's room, Resident 5 was lying in her bed wearing a gown. Resident 5's incontinence brief was soiled, her hair was unkempt, and her fingernails were long with ragged edges and a black-colored substance underneath them. Resident 5 stated she likes to keep her fingernails long but wants them to be clean. Resident 5 cried and stated she felt uncomfortable sitting in a soiled brief for an extended period. Resident 5 stated she wanted to get out of bed today, but she has not seen her nurse since this morning. During an observation and interview on 5/1/2026 at 2:22 p.m., Certified Nursing Assistant (CNA) 1 stated Resident 5 refused to be changed at the start of the shift (7 a.m.) today and he did not return to check on Resident 5 because he knew Resident 5 refused care anyway. CNA 1 confirmed Resident 1 was still in bed in her gown, was unkempt, and had long unclean fingernails. CNA 1 stated he should have checked on Resident 5 and help with her ADLs to provide comfort, prevent skin breakdown and infection. During a concurrent observation and interview (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	05/05/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 5/1/2026 at 2:34 p.m., Licensed Vocational Nurse (LVN) 1 stated she had not been informed by CNA 1 that Resident 5 initially refused assistance with her care. LVN 1 stated CNA 1 should have notified her so she could offer assistance and ensure Resident 5's care needs were met. LVN 1 confirmed Resident 1 was crying, remained in bed wearing a gown, and had unkept hair, long unclean fingernails, and a soiled brief. LVN 1 stated it is important for nursing staff to offer and provide assistance with residents' ADLs in a timely manner to prevent neglect and promote dignity. During an interview on 5/4/2026 at 12:58 p.m., the Senior Nurse Executive (SNE) stated CNA 1 should have rechecked Resident 5 and re-offered assistance with her ADLs and should have involved LVN 1 to ensure timely provision of Resident 5's care needs. SNE stated the nursing staff are expected to provide the residents with assistance during their ADLs and must collaborate to find ways to provide the residents' care without delay promoting dignity and quality of life. During a review of the facility's policy and procedure (P&P) titled, Dignity, revised 10/2024, the P&P indicated the facility, and its staff shall care for each resident of the facility in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. During a review of the facility's P&P titled, Quality of Life-Dignity, revised 11/8/2024, the P&P indicated the facility shall provide each resident care in a manner that promotes and enhances quality of life, dignity, respect and individuality by providing support in their personal grooming, independence and meaningful engagement. During a of the facility's P&P titled, Routine Resident Care, revised 10/2024, the P&P indicated the facility shall ensure the residents of the facility receive necessary assistance, but not limited to maintaining good grooming and personal/oral hygiene and assisting with tasks of daily living such as personal hygiene, toileting, bed mobility, transfer and locomotion on and off the unit.

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	05/05/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Registered Nurse Supervisor (RNS) 1 completed and accurately documented the Discharge Summary for one of two sampled residents (Resident 6) when Resident 6 was discharged home on 4/13/2026.This deficient practice resulted in Resident 6's skin condition not depicted accurately upon Resident 6's discharge and had the potential for his continuity of care to be interrupted and/or delayed.Findings:During a review of Resident 6's admission Record (Face Sheet), the Face Sheet indicated Resident 6 was admitted to the facility on [DATE]. Resident 6 had diagnoses including multiple pressure ulcers ([pressure injury] localized damage to the skin and/or underlying tissue usually over a bony prominence) and type 2 diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 6's Minimum Data Set ([MDS] a resident assessment tool) dated 4/14/2026, the MDS indicated Resident 6 was able to make decisions that were reasonable and consistent and required one-person assist to complete his activities of daily living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) such as bathing and walking up and down the stairs. The MDS indicated Resident 6 was continent (full control) of bladder and bowel functions.During a review of Resident 6's Attending Physician's Skilled Nursing Facility Discharge Instructions (Discharge Instructions) dated 4/13/2026 and timed at 12:18 p.m., the Discharge Instructions indicated Resident 6 was to be discharged home and had the following pressure injuries: left upper back, left gluteus (buttock), right gluteus, and posterior (back) neck. The Discharge Instructions indicated the treatment for all identified pressure injuries was to cleanse each wounds/skin injury with normal saline (a sterile mixture of water and salt used to flush wounds), pat dry, apply Manuka Medi-Honey (a sterile, medical grade natural ointment made from manuka honey used to treat infected, slow healing or chronic wounds, burns and abrasions) and cover with a silicone-bordered foam dressing (used to protect and heal acute and chronic wounds such skin pressure injuries and other ulcers or surgical incision).During a review of Resident 6's Facility Discharge summary dated [DATE] and timed at 1 p.m., the Facility Discharge Summary indicated Resident 6 was discharged home with intact skin. There was no documentation indicating any existing skin conditions or indicating that any wound care or skin treatment was required after discharge During a telephone interview on 5/5/2026 at 10:33 a.m., Registered Nurse Supervisor (RNS) 1 stated she did not complete a skin assessment of Resident 6's prior to discharge and did not document Resident 6's condition and did not document Resident 6's skin condition or any pressure injury treatment in the Facility Discharge Summary. RNS 1 stated the Treatment Nurse (TN) was responsible for performing the skin assessment and documenting the findings in Resident 6's medical record. During an interview on 5/5/26 and timed at 11:35 a.m., the Senior Nurse Executive (SNE) stated RNS 1 should have performed a skin assessment of Resident 6 prior to discharge and should have documented in the Facility Discharge Summary of Resident 6's skin condition with specific treatment to each wound identified, to reflect Resident 6's accurate skin condition on discharge and to ensure continuity of his care. The SNE stated it was the responsibility of RNS 1 to ensure Resident 6's Facility Discharge Summary was complete and all information on Resident 6's general condition is depicted on the document.During a review of the facility's undated Registered Nurse Job Description, the Job Description indicated the Registered Nurse shall implement and maintain established nursing objectives and standards by providing direct care to the residents, verifying the residents' treatment, assisting in the planning of the residents' discharge, and completing the transfer and/or discharge forms in accordance with the facility's procedures.During a review of the facility's policy and procedure (P&P) titled, Discharging the Resident, revised 12/2016, the P&P indicated the residents' skin condition shall be assessed and documented at the time of discharge.During a review of the (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	05/05/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's P&P titled, Transfer or Discharge Documentation, revised 12/2016, the P&P indicated the residents' details of transfer and/or discharge and all other necessary information, including a copy of the residents' discharge summary shall be completed to ensure a safe and effective transition of care.