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	06/03/2026

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and a review of records, the facility failed to ensure one of three sampled residents (Resident 1) had her right to receive visitors of her choice and to have her visitation preferences considered prior to imposing restrictions.This deficient practice resulted in Resident 1 being unable to receive visits from her son in her room as she preferred, and had the potential to negatively impact her emotional wellˆbeing, quality of life, and resident rights.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with a diagnoses including hemiplegia (paralysis of one side of the body), cerebral infarction (loss of blood flow to a part of the brain), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, lower body dressing and putting on and taking off shoes.During a review of Resident 1's History and Physical (H&P) dated 3/27/2026, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions.During an interview on 6/3/2026 at 8:15 a.m., with Resident 1, Resident 1 stated her son was not abusing her and denied that he had any intention of harming her. Resident 1 became tearful and said she wanted her son to continue visiting her. She also stated the facility forced her to have visits with her son only in the family room or other common areas instead of in her room as she preferred.During an interview on 6/3/2026 at 9:06 a.m., with Family Member (FM) 1, FM 1 stated he visited his mother five days per week from 9 a.m. to 5 p.m. He stated, he had been playing with his mother and trying to make her laugh when he pinched her left thigh. He stated LVN 1 told him he was abusing his mother and reported the incident to the Chief Clinical Officer (CCO) and the Administrator. He stated no other witnesses were present at the time of the incident. He stated approximately two weeks ago, following the incident, the Administrator told him he could not visit his mother in her room and notified FM 2 his visits were limited to the family room or the front area of the facility. He stated he was not provided with any documentation regarding the visitation restriction. He further stated that his mother cried and expressed a desire to see him in her room.During an interview on 6/3/2026 at 11:07 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she witnessed FM 1 pinch Resident 1 on her left thigh. She stated she entered Resident 1's room and observed the resident lying in bed asleep. She stated FM 1 asked his mother if she wanted him to pinch her and then pinched Resident 1 on her left thigh. She stated Resident 1 awoke after the incident and began swinging her arms. She stated she exited the room and notified the Registered Nurse Supervisor (RNS), who instructed her to inform the Chief Clinical Officer (CCO) and the Administrator. She stated she subsequently informed both the CCO and the Administrator of the incident. She stated the CCO and Administrator instructed her to return to the resident's room and reenact what she had observed. She stated the CCO and Administrator interviewed Resident 1 following the incident, and Resident 1 reported that she was not afraid of her son and did not want him to stop visiting. She stated the RNS and the CCO completed a skin assessment following the alleged incident and found no bruising, redness, swelling, or other visible signs of injury.During an interview on 6/3/2026 at 4:00 p.m., with the CCO, the CCO stated (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 1 informed her of the alleged incident in which FM 1 pinched Resident 1's left thigh. The CCO stated when she interviewed Resident 1, the resident reported she was not afraid of her son and believed he had been joking. The CCO stated Resident 1 expressed a desire for her son to continue visiting. She stated the facility implemented a visitation restriction that limited visits to designated common areas and the family room while the allegation was under investigation. She stated FM 1 was notified of the restriction by telephone. She stated the facility did not explain grievance or appeal rights related to the visitation restriction to either Resident 1 or FM 1. She stated the facility did not fully consider Resident 1's visitation preferences before implementing the restriction. She stated the facility's investigation into the allegation involving Resident 1's son was determined to be inconclusive. The CCO stated no bruising, redness, swelling, or other injury was identified during the postˆincident skin assessment. She stated restricting a resident's visitation without considering the resident's preferences may negatively affect the resident's emotional wellˆbeing and quality of life, and residents may experience sadness, loneliness, and feelings of isolation when they cannot receive visits from family members according to their wishes.During a review of the facility's policy and procedure titled, Visitation, dated 2016, the P&P indicated, Residents have the right to receive visitors of their choosing subject to reasonable clinical and safety restrictions, in a manner that does not impose on rights of other residents.

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(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 provide necessary activities of daily living ([ADLs] daily self-care activities) care and services for two of three sampled residents (Resident 1 and 2), who were dependent (helper does all the work) on staff for incontinence care (the help someone gets when they have accidental urine or stool leaks). This was evidenced by the following: 1.Resident 1 was observed with a soiled incontinence brief (diaper) containing urine and stool.2.Resident 2 was observed with urine-soiled towel positioned between her legs, which was not consistent with facility practice for managing incontinence.These deficient practices placed Resident 1 and 2 at risk for skin breakdown, worsening skin integrity, infection, discomfort, compromised dignity and decreased quality of life. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with a diagnoses including hemiplegia (paralysis of one side of the body), cerebral infarction (loss of blood flow to a part of the brain), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, lower body dressing and putting on and taking off shoes.During a review of Resident 1's Care Plan titled Resident has bowel incontinence dated 3/20/2026, revised 04/02/2026, the care plan indicated interventions including to check resident and assist with toileting as needed, provide peri care (cleaning of the genitals and anal areas) after incontinent episodes.During a review of Resident 1's History and Physical (H&P) dated 3/27/2026, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Care Plan titled Resident has actual impairment to skin integrity related to moisture associated incontinence dermatitis (skin inflammation caused by prolonged exposure to urine or feces) of the right inner thigh dated 3/27/2026, revised on 3/29/2026, the care plan interventions indicated to keep skin clean and dry, and minimize excessive moisture.During a review of Resident 1's Nursing-Skin Check dated 4/22/2026, the Nursing-Skin Check indicated, perianal (the area located immediately around the anus) moisture acquired skin damage ([MASD] inflammation and erosion of the skin caused by prolonged exposure to moisture).During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], with a diagnoses including hemiplegia, and cerebral infarction.During a review of Resident 2's Care Plan titled Resident has an ADL self-care performance deficit related to activity intolerance dated 3/11/2021, the care plan interventions indicated to assist with transfers, turning and/or repositioning at least every two hours, maintain good personal hygiene every shift and as necessary (prn).During a review of Resident 2's H&P, dated 5/9/2026, the H&P indicated, Resident 2 had the capacity to understand and make decisions.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was dependent (helper does all the effort) with toileting, showering, lower body dressing and putting on and taking off shoes.During a concurrent observation and interview on 6/3/2026 at 8:15 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 1 was observed with a soiled incontinence brief containing stool and urine. A dressing was present on the sacrococcyx (tail bone) area. LVN 2 stated Resident 1 was dependent on staff for all ADL care, including incontinence care and hygiene. LVN 2 state prolonged exposure to urine and stool increased the risk of skin breakdown, pressure injuries, and infection. LVN 2 stated that a resident in that condition could experience discomfort, decreased dignity, embarrassment, and distress, and that such conditions could negatively affect overall wellˆbeing and skin integrity.During a concurrent observation and interview on 6/3/2026 at 8:30 a.m. with Certified Nurse Assistant (CNA) 1, Resident 2 was observed lying in bed with a urineˆsoiled towel positioned between her legs. CNA 1 stated Resident 2 was incontinent of urine and stool. She stated that her shift began at 7:00 a.m. and that her routine (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included initial rounds at the start of the shift, with incontinence care provided approximately every two hours and as needed. CNA 1 stated she was unable to confirm the last time Resident 2 was checked or changed prior to the observation. She stated she had not yet provided care to Resident 2 at the time of the observation because she had been assisting with meal trays and helping another CNA. She stated she did not know why a towel was positioned between Resident 2's legs and confirmed this was not part of the resident's care plan. She stated Resident 2 did not refuse incontinence care. CNA 1 stated allowing a resident to remain in a wet or soiled condition could cause discomfort, embarrassment, and affect the resident's dignity.During a telephone interview on 6/3/2026 at 9:06 a.m. with Family Member (FM) 1, FM 1 stated he visited his mother five days per week from 9 a.m. to 5 p.m. He stated he had observed his mother remaining soiled for the past three months. He stated during his visits, he observed his mother not being changed for up to four hours.During an interview on 6/3/2026 at 1:41 p.m. with the Unit Director of Nursing (UDON), the UDON stated Resident 1 should be checked and changed every two hours and as needed. She stated Resident 1 was at increased risk for skin breakdown due to incontinence, immobility, diabetes, and dependence on staff for care. She stated Resident 1's FM 1 had reported concerns Resident 1 was not being changed in a timely manner. She stated she had identified staff noncompliance related to incontinence care and acknowledged that Resident 1 was found soiled with urine on three occasions during her rounds. She stated that she notified the assigned CNA each time these observations were made. The UDON stated towels were not an approved incontinence management intervention and were not intended to replace incontinence briefs, scheduled toileting, or routine incontinence care. She stated using a towel between a resident's legs may not adequately protect the resident's skin from exposure to urine or stool and may contribute to moistureˆrelated skin issues if not promptly identified and addressed.During a telephone interview on 6/3/2026 at 3:48 p.m. with Certified Nurse Assistant (CNA) 3, CNA 3 stated she began her shift at 11:00 p.m. and conducted initial rounds at the start of the shift. She stated she worked the night shift from 11:00 p.m. to 7:00 a.m. and was assigned to Resident 1 on the morning of the observation. She stated, she rounded on her assigned residents at the beginning of her shift and continued to round every two hours and as needed. CNA 3 stated Resident 1 was dependent on staff for all activities of daily living, including toileting, hygiene, and incontinence care. She stated the last time she provided incontinence care to Resident 1 was approximately 4:00 a.m., and that Resident 1 was cleaned and changed at that time. She stated staff should not use towels in place of incontinence pads. She stated prolonged exposure to urine and feces could cause discomfort, skin irritation, and negatively affect a resident's quality of life. CNA 3 stated she cleaned Resident 1 at approximately 5:00 p.m. during her prior shift and that the resident was changed again at 4:00 a.m. She stated staff should not leave towels between residents' legs and the only resident for whom towels were being used in this manner was Resident 2, due to an ulcer on her anus. She also stated that the facility had routinely used a towel for that purpose.During an interview on 6/3/2026 at 4:00 p.m. with the Chief Clinical Officer (CCO), the CCO stated she was aware of concerns raised by Resident 1's FM 1 regarding incontinence care, skin integrity, the condition of Resident 1's gastrostomy tube ([GT] a soft tube surgically inserted directly into the stomach to administer medication, fluids and nutrition) , and concerns about LVN 1's interactions. The CCO stated Resident 1 was dependent on staff for activities of daily living, including toileting, hygiene, repositioning, and incontinence care. She stated dependent residents should be checked and changed routinely, including every two hours and as needed, in accordance with the resident's care plan and identified needs. The CCO that prolonged exposure to urine and feces could place a resident at risk for skin breakdown, pain, infection, and worsening of existing wounds. She stated the use of towels between a resident's legs was not an approved incontinence management intervention and was not intended to replace incontinence briefs or routine incontinence care.During a review of the facility's policy and procedure (P&P) titled, Incontinence Care, dated 10/2024, the P&P indicated, It is the policy of this facility to promote skin hygiene, minimize risk of infection, and facilitate skin integrity by providing incontinent care as needed to residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an infection control and prevention designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection for one of three sampled residents (Resident 1) by failing to:1.Ensure ongoing assessment and monitoring of Resident 1's gastrostomy tube ([GT] a soft tube surgically inserted directly into the stomach to administer medication, fluids and nutrition) for signs of deterioration or contamination.2.Ensure appropriate infection prevention measures were implemented for Resident 1 being treated for suspected scabies (a contagious skin infestation caused by tiny, [mites]- closely related to spiders and ticks).These deficient practices had the potential to result in the transmission of infectious conditions, delayed identification of infection-related concerns, impaired delivery of medications and nutrition, and increased risk of infection and other adverse health outcomes.Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with a diagnoses including hemiplegia (paralysis of one side of the body), cerebral infarction (loss of blood flow to a part of the brain), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 1/28/2025, the MDS indicated Resident 1 was dependent (helper does all the effort) with toileting, showering, lower body dressing and putting on and taking off shoes.During a review of Resident 1's History and Physical (H&P) dated 3/27/2026, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions.1.During an interview on 6/3/2026 at 11:07 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1's GT appeared dark or black in color and looked moldˆlike. She stated she reported this to the Unit Director of Nursing (UDON) on 4/21/2026, and Resident 1 was sent to a General Acute Care Hospital (GACH) for replacement, returning to the facility on 4/22/2026. LVN 1 was unable to state when the resident's GT tubing was last assessed. She stated the GT should be assessed routinely, including at least every shift and during medication administration, to ensure proper placement, patency, and condition prior to use. She stated an abnormal or contaminated gastrostomy tube could place a resident at risk for infection, including localized site infection.2.During a concurrent interview and record review on 6/3/2026 at 1:41 p.m. with the Unit Director of Nursing (UDON), Resident 1's Medication Administration Record (MAR) dated May 2026 was reviewed. The MAR indicated Ivermectin, (an antiˆparasitic medication used to treat infections and prescribed offˆlabel for scabies) three milligram (mg-unit of measurement), give nine milligrams via GT one time a day, every seven days for four weeks, starting on 05/10/2026 at 9:00 a.m. The UDON stated Ivermectin was ordered and administered as prophylactic treatment due to a suspicion of scabies. She stated suspected cases of scabies should be reported and residents suspected of having scabies should be placed on contact precautions (precautions intended to prevent transmission of infectious agents) until scabies was confirmed or ruled out. The UDON stated Resident 1 was not placed on contact precautions. She stated significant changes in a resident's condition, such as suspicion of scabies, should be incorporated into the resident's care plan to ensure staff were aware of the resident's needs and required interventions.During an interview on 6/3/2026 at 3:39 p.m. with the Infection Preventionist (IP), the IPN stated Resident 1 was treated for suspected scabies and was prescribed Ivermectin as part of her treatment plan. She stated that no skin scraping (a minimally invasive diagnostic procedure in which superficial layers of the skin are gently scraped for examination), was performed when Resident 1 developed a rash in 5/2026. She stated a skin scraping was not performed because Resident 1 had undergone one in 2/2026. The IP stated the Physician Assistant made the determination to treat Resident 1 for suspected scabies. She stated that a repeat skin scraping could have been considered to help determine the cause of the rash. The IP stated contact precautions should have been implemented to reduce the risk of transmission and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate isolation was intended to protect other residents, staff, and visitors from potential exposure while the resident was being evaluated and treated. The IP state contact precautions were not initiated for Resident 1.During an interview on 6/3/2026 at 4:00 p.m. with the Chief Clinical Officer (CCO), the CCO stated she became aware of concerns regarding the condition of Resident 1's GT on 4/21/2026 after LVN 1 reported discoloration and dark residue within the tube. The CCO stated GT should be assessed routinely every shift, during medication administration, and as needed to identify abnormalities, deterioration, blockage, leakage, or signs of infection. She stated failure to identify abnormalities in a timely manner may place a resident at risk for infection and other medical complications requiring additional intervention. The CCO stated Resident 1 was treated with Ivermectin for suspected scabies. She stated when a resident presents with signs or symptoms consistent with possible scabies, the resident's skin should be assessed, the physician should be notified, and further evaluation-including dermatology consultation and skin scraping should be considered as clinically indicated. The CCO stated infection prevention measures, such as placing the resident in contact isolation, should be implemented.During a review of the facility's policy and procedures (P&P) titled, Scabies, dated 4/2006, the P&P indicated Implement Contact Isolation. During a review of the facility's P&P titled, Gastrostomy and Jejunostomy Care, dated 5/2026, the P&P indicated, The purposes of this procedure are to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection.