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 02/15/2025
NAME OF PROVIDER OR SUPPLIER: Sunnyside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 22617 So. 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review , the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect on one of three sampled residents (Resident 17) by standing over the resident while assisting her during a meal. This failure had the potential to result in decreased self-esteem and self-worth on Resident 17. Findings: During a review of Resident 17's Admission Record, the Admission Record indicated the resident was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included cerebral ischemia(condition that occurs when there is a reduction of blood to the brain), dementia(a progressive state of decline in mental abilities),and dysphagia(difficulty of swallowing). During a review of Resident 17's History and Physical (H&P),dated 7/26/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 17's Minimum Data Set (MDS- resident assessment tool), dated 12/18/2024, the MDS indicated the resident had severely impaired cognitive skills (problems with person's ability to think, learn, remember, use judgement, and make decisions) and required substantial/maximal assistance(helper does more than half the effort) with eating, dressing, oral hygiene, and personal hygiene. During a review of Resident 17's Care Plan about activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily), revised 3/19/2024, the care plan indicated the resident had adl self-care deficit related to dementia, and cognitive impairment(a condition that makes it difficult to learn, limited mobility and activity intolerance). The Care Plan indicated interventions that included provision of substantial assistance with one person assist with eating during meals. During a review of Resident 17's Order Summary Report dated 11/6/2024, the Order Summary Report indicated fortified diet(food with nutrients added) mechanical diet/ground texture (diet of soft foods that are easy to chew and swallow). (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: 056488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 17's Order Summary Report dated 7/12/2024, the Order Summary Report indicated 1:1 assistance (individualized support) with meals. During an observation on 2/12/2025, at 1:08 p.m. in Resident 17's room, Certified Nursing Assistant (CNA 3) was standing over Resident 17 while feeding the resident. During an interview on 2/15/2025, at 2:00 p.m. with CNA 5, CNA 5 stated when helping a feeder (a resident who needs help with eating) the CNA should be in sitting in front of the resident to ensure clear communication between the staff and resident and for resident's comfort. CNA 5 stated residents should be fed within eye level to maintain resident's dignity. During an interview on 2/14/2025, at 9:07 a.m. with CNA 4, CNA 4 stated we should be sitting down next to the resident when feeding a resident to ensure the resident swallowed and chewed the food because standing over the resident could affect their dignity and might make them feel that she was rushing to feed the resident. During an interview on 2/15/2025, at 3:12 p.m.with Director of Staff Development (DSD), DSD stated CNA3 should have sat down next to the resident so she would be within eye level ensuring resident's dignity is maintained. During an interview on 2/15/2025, at 7:24 p.m. with Chief Clinical Officer (CCO), CCO stated residents who need assistance with meals should be fed with the CNA sitting down and within eye level. CCO stated the CNA feeding the resident within eye level and sitting down could prevent aspiration by visually seeing the resident's mouth. During a review of facility's policy and procedure (P&P) titled Dignity revised 10/2024, the P&P indicated the facility will provide residents with dignified dining experience to promote and enhance their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49862 Based on observation, interview and record review, the facility failed to ensure Certified Nursing Assistance (CNA7) close the privacy curtain to ensure a resident would not be visually exposed to the roommates and others while providing personal care for residents 1 out or 10 sample resident (Resident 23). This deficient practice violated the resident's right for privacy. Findings: During review of Resident 23's Admission Records , the Admission record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses anxiety (conditions that cause excessive and persistent feelings of fear or worry that can interfere with daily life), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 23's Minimum Data Set (MDS aresident assessment tool), dated 10/01/2024, the MDS indicated Resident 23'srequired dependent (helper does ALL the efforts, resident does none of the effort to completes activity or the assistance of 2 or more helpers is required for resident to complete the activity During an observation on 2/13/25 at 09:31am During Resident 23's ADL care, Resident 23 was exposed half naked with privacy curtain wide open. Certified Nursing Assistant (CNA7) stated Resident 23 just came out from shower, CNA 7 stated she went to go get towels outside so she left the curtain open. During an interview on 02/13/2024 at 03:26PM with CNA 7. CNA 7 stated the privacy curtain should have been closed all the way, when going out of room to get towels, but her helper left for an appointment. CNA7 stated she supposed to close the curtain all the way and call for help. CNA 7 stated Resident 23 will feel embarrassed and expose to others during personal care. During an interview on 2/15/25 at 03:23 p.m., with the Chief Clinical Officer (CCO),. The DON stated staffs needs to ensure privacy curtain is completely closed all the way for all residents, resident will be embarrassed and be ashamed. During a record review of the facility's dated policies and procedures titled Dignity, section 11. indicated Staff promotes, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to reassess the Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) for one of three sampled residents (Resident 3) by failing to ensure PASRR level 1 was submitted when the resident was diagnosed with mental illness and was placed on antipsychotic medicine (medicines used to treat mental illnesses). This deficient practice placed Resident 3 at risk of not receiving necessary care and services they need. Findings: During a review of Resident 3's Admission Record, the Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included unspecified psychosis(a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), end stage renal disease (ESRD-irreversible kidney failure), anxiety disorder, and unspecified dementia (a progressive state of decline in mental abilities). The Admission Record indicated the resident was diagnosed with psychosis on 8/14/2024 and anxiety disorder on 11/11/2023. During a review of Resident 3's History and Physical (H&P), dated 3/28/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS-resident assessment tool), dated 11/16/2024, the MDS indicated the resident had moderately cognitive impairment (a person had trouble with memory, learning , thinking , and reasoning skills) and required substantial/ maximal assistance (helper does more than half the effort) with bed mobility, transfer to and from a bed to a chair, and dressing. The MDS indicated the resident had diagnoses of anxiety disorder and psychotic disorder. The MDS indicated the resident was on antipsychotic and anti-anxiety medications. During a review of Resident 3's PASSR Level 1 Screening (PASSR), dated 11/11/2023, the PASSR Level I Screening indicated the resident was screened for initial Preadmission screening , had no serious diagnosed mental disorder and did not require a PASSR Level 2 Screening(more in-depth evaluation as part of PASSR process). During a review of Resident 3's Care Plan, initiated 11/22/2023 and revised on 2/10/2025, the care plan indicated the resident had a behavior of paranoid delusions (false beliefs that someone is being threatened, harmed or mistreated with diagnosis of psychosis disorder. During a review of Resident 3's Order Summary Report, dated 9/2/2024, the Order Summary Report indicated an order of Buspirone (medicine used to treat anxiety) 10 milligrams(mgs.- unit of measurement) give 2 tablet by mouth two times a day for anxiety manifested by random or repetitive questions and statements. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Order Summary Report, dated 9/1/2024, the Order Summary report indicated an order of quetiapine fumarate (medicine used to treat psychosis)25 mgs. one tablet by mouth two times a day for psychosis manifested by paranoid delusions. During a concurrent interview and record review of Resident 3's PASSR Level 1 Screening, dated 11/1/2023, Admission Record and MDS dated [DATE] on 2/15/2025, at 12:33 p.m. with Director of Medical Records (DMR), DMR stated she missed Resident 3's status change. DMR stated Resident 3 was diagnosed with psychosis, and anxiety disorder. DMR stated the residents was also receiving antipsychotic and anti-anxiety medicines. DMR stated once Resident 3 was placed on anti-psychotic , Minimum Data Set Coordinator (MDSC1) should have assessed the resident and notified her to do a resident review and submit another PASSR 1 Level Screening. DMR stated Resident 3 could benefit from other programs related to his mental illness or referral to appropriate agencies if needed . DMR stated not reassessing Resident 3 PASSR Level 1 had the potential to delay of care and services. During an interview on 2/15/2025, at 12:54 p.m. with MDSC1, MDSC 1 stated she coordinated with Medical Record regarding PASSR Level 1 Screening. MDSC 1 stated Resident 3 's PASSR Screening was missed by the facility. MDSC1 stated once the resident is placed on antipsychotic , the MDSC should have notified medical records to coordinate for PASSR Level 2 Screening. MDSC1 stated MDSC usually identified residents who are on antipsychotic medicines and let Medical Records know so they can update the PASSR Screening for the resident. MDSC 1 stated PASSR Screening is important to ensure the resident is properly placed in the facility and receiving appropriate services or treatments. During a review of facility's policy and procedure (P&P) titled Pre-Admission Screening and Resident Review revised 2/2025, the P&P indicated if there has been a significant change in the individual's condition at any point, the individual must receive a new Level 1 screening. The P&P indicated the facility must notify the state-designated mental health or intellectual disability authority promptly when a resident with mental disease or intellectual disability experiences a significant change in mental or physical status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interview and record review the facility failed to ensure two of five reviewed residents (Resident 129 and 80) were administered blood pressure medications safely and in accordance with physician's orders and by failing to ensure: 1. Resident 129's Amlodipine (a medication used to treat high blood pressure) 5.0 (five) milligrams ([mg] - a unit of measure for weight) powder from the crushed medication was mixed with water before administration and medication cup was rinsed with water to ensure resident received the full dose via gastrostomy tube ([GT] - a soft tube surgically inserted into the stomach to administer medications, fluids, and nutrition). This deficient practice placed Residents 129 at risk for GT clogging leading to discomfort/pain and GT replacement and not receiving full dose of BP medication (Amlodipine). 2. Resident 80 was reassessed for abnormal blood pressure (BP) values (systolic blood pressure [SBP- top number] and diastolic blood pressure [DBP - bottom number] measured in millimeters of mercury ([mm Hg] unit to measure pressure), when the prescriber's order included a parameter to determine when to hold or administer a BP medication to the resident. This deficient practice placed Residents 80 at risk for low blood pressure (the pressure of blood on the walls of the arteries as the heart pumps blood around your body) when a physician's parameters (specific instructions that you can measure before medication administration) for administration of Amiodarone (heart medication), Midodrine (used to treat low blood pressure) and Metoprolol (blood pressure medication) were not followed. Findings: During a review of Resident 129's Admission Record, the Admission Record indicated Resident 129 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (is a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (a stroke that occurs when blood flow to the brain is blocked) affecting left non-dominant (use consistently for task) side, hypertension (high blood pressure), with GT in place. During a review of Resident 129's, Minimum Data Set ([MDS] - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 129's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision-making were severely impaired. Resident 129's MDS indicated the resident was dependent on staff physical assistance for all Activities of Daily Living ([ADLs]- eating, bathing, or showering, dressing, getting in and out of bed or a wheelchair, toileting, and personal hygiene). During a review of Resident 129's, History and Physical (H&P) dated 1/11/2025, the H&P indicated Resident 129 did not have the capacity to understand and make decisions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 129's, Physician Order Summary Report dated,1/8/2025 the Physician Order Summary Report indicated Resident 129 had the following orders: 1.Amlodipine (Norvasc) 5.0to be given via GT one time a day, scheduled at 12:00 p.m., for hypertension, hold if SBP (pressure in the arteries when the heart contracts and pumps blood throughout the body) is less than 110 mmHg, ordered on 1/9/2025. 2. May crush crushable medication and mix with the appropriate vehicle (liquid or base in which a medication is mixed to be administered), ordered on 1/8/2025. During a review of Resident 129's, Care Plan titled Resident 129 had hypertension (HTN) and CVA dated 12/19/24, the Care Plan indicated a goal to implement interventions to assist the resident in achieving a blood pressure within normal limits. During a medication pass observation on 2/11/2025 at 1:20 p.m., the Licensed Vocational Nurse (LVN) 2, was observed crushing one tablet of Amlodipine 5.0 mg tablet and entered the Resident 129's room. LVN 2 was observed initially flushed GT with water and then poured directly into the GT the crushed Amlodipine tablet that was in a powder form. LVN 2 was observed to follow with GT final water flush. The medication cup was observed to have the residual of powdered Amlodipine along the walls and at the bottom. During an interview on 2/11/2025 at 1:42 p.m., with LVN 2, LVN 2 looked inside of Resident 129's medication cup that contained white powder and stated, the resident did not receive the full dose. LVN 2 stated she should have added water to the crushed Amlodipine prior to administering the medication through the GT and should have made sure Resident 129 was administered the full dose of medication. During an interview on 2/13/2025 at 9:27 a.m., with a Registered Nurse (RN) 1 and UDON 2 on Station 200, RN 1 stated that crushable medication should be mixed with 5.0 (five) ml of water to completely dissolve the medication before administering it via GT. RN 1 stated if medication residual (left over medication) is in the cup the licensed nurse must add more water to make sure all of the medication was administered to the resident to prevent under dosing of medication. During a review of the facility's Policy and Procedure (P&P) titled, General Guidelines for Administering Medication via Enteral Tube, dated 11/2021, the P&P indicated, The powder from each medication is mixed with water (sterile water for irrigation is preferred) before administration. The souffle cup is rinsed with water to get all of the medication. 2. During a review of Resident 80's Admission Record, the Admission Record indicated Resident 80 was admitted on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection that affects one or both lungs), Atrial fibrillation ([AFib]- is an irregular and often very rapid heartbeat), hypotension (low blood pressure), chronic (long-term) diastolic congestive heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and dependence on renal dialysis (a procedure remove waste products and excess fluid from the blood when the kidneys stop working properly). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 80's, MDS dated [DATE], the MDS indicated Resident 80's cognition was intact. The MDS indicated Resident 80 required substantial/maximal assistance (helper does more than half the effort) to total dependence (helper does all the effort) upon facility staff for ADLs. During a review of Resident 80's, Physician Order Summary Report dated 2/7/2025, the Physician Order Summary Report indicated Resident 80 had orders for: a. Amiodarone 200 mg, e one tablet by mouth two times a day (9 a.m. and 5 p.m.) for coronary artery disease ([CAD] occurs when blood vessels that carry blood to the heart get blocked with plaque [fatty deposits]) hold if SBP is less than 110 mmHg, order start date 2/7/2025. b. Metoprolol (used to treat high blood pressure, 25 mg, give one half tablet (12.5 mg) by mouth two times a day (9 a.m. and 5 p.m.) for hypertension, hold if SBP is less than 90 or heart rate ([HR] the number of times your heart beats in a minute [bpm]) is less than 55 bpm, order start date 2/7/2025. c. Midodrine (medication used to treat low blood pressure) 10 mg, give one- and one-half tablet (15 mg) by mouth three times a day (9 a.m., 1 p.m., and 5 p.m.) for hypotension, hold if SBP is greater than 130 mmHg, order start date 2/7/2025. During a review of Resident 80's, Care Plan titled Resident 80 has altered cardiovascular (heart) status related to congestive heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypotension, dated 1/28/2025, the Care Plan interventions indicated, administer medications as ordered, observe for side effects and effectiveness, observe vital signs (include blood pressure, heart rate, respiration (breathing rate), body temperature, and oxygen saturation ([the percentage of oxygen in your blood] which are indicators of health status) as ordered and to notify medical doctor (MD) of significant abnormalities. During a review of Resident 80's ,Care Plan titled, Resident 80 has hypotensive heart disease, A-fib dated 1/16/2025, the Care Plan indicated the interventions included to observe vital signs, notify MD of significant abnormalities, observe/document/report to the MD as needed (PRN) any signs and symptoms of hypotension: dizziness, fainting, syncope, blurred vision, lack of concentration, nausea, fatigue, cold clammy pale skin, give medications as ordered and observe for side effects and effectiveness. During a concurrent medication pass observation and interview on 2/12/2025, between 8:42 a.m. to 9:08 a.m. , with LVN 1, on Station 200 at MedCart 200, the following was observed and interviews included: 1. On 2/12/2025 at 8:42 a.m., LVN 1 stated that he was inputting vital signs into the computer that was taken by a Certified Nurse Assistant (CNA) 1. LVN 1 showed a handwritten paper with seven residents names and vital signs that included BP readings written on a piece of paper. 2. On 2/12/2025 at 8:47 a.m., LVN 1 was observed entering the pre-written vital signs into the computer that included BP reading for Resident 80 which indicated a BP of 84/44 mmHg (normal BP reference range is 120/80 to 129/79). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 2/12/2025 at 8:50 a.m., LVN 1 stated he will hold (not administer) Resident 80's Amiodarone because Resident 80's SBP was less than 110 and he will hold Resident 80's Metoprolol because the Resident 80's SBP was less than 90 mmHg, and the heart rate was less than 55 bpm. LVN 1 was not observed checking or assessing Resident 80's BP or heart rate. During a concurrent observation and interview on 2/12/2025 at 9: 04 a.m., LVN 1 was asked to recheck Resident 80's BP. LVN 1 used an automated (automatic) BP machine. LVN 1 stated the Resident 80's BP was 104/52 mmHg. LVN 1 stated he will re-enter Resident 80's BP reading into the computer and will prepare and give Resident 80's BP medication of Metoprolol as the resident's SBP was within the parameter ordered by the physician to administer Metoprolol. During an interview on 2/12/2025 at 9:15 a.m., LVN 1 stated, We have to follow the parameters that the doctor set. LVN 1 stated that he would not know if Resident 80 had BP within the acceptable parameters for medication administration Metoprolol, Amiodarone, or Midodrine, if he did not recheck the resident's BP just before medication administration. LVN 1 stated that he did not know at what time CNA1 t had checked Resident 80's BP. During an interview on 2/13/2025 at 9:35 a.m., with a Registered Nurse (RN) 1 and a Unit Director of Nursing (UDON) 2 on Station 200, RN 1 stated, it is the job of the charge nurse to check the vital signs including BP prior to medication administration, especially medications to control BP that have a parameter to determine when to give or not give the BP medication. UDON 2 stated the BP taken by CNAs in the morning was just to see how the residents were doing. UDON 2 stated, when it comes to administering medications the charge nurse must do their own BP check and monitoring. During a concurrent interview and record review on 2/13/2025 at 9:44 a.m., with RN 1 and UDON 2, Resident 80 vital signs taken on 2/12/2025 in the morning by CNA 1 were reviewed. RN 1 stated the charge nurse cannot rely on the CNAs morning BP checks. RN 1 stated the charge nurse should evaluate and reassess the resident before making medication administration decisions. During a review of the facility's P&P titled, Vital Signs Monitoring Procedure, dated 2/2025, the P&P indicated, Nursing staff must document, report, and act on abnormal findings promptly .Vital Signs must be checked .Before and after medication administration (e.g., antihypertensives, cardiac drugs, and pain medications). During a review of the facility's P&P titled, Administration Procedures For All Medications, dated 6/2021, the P&P indicated, Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. Cross Reference F759

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on observation, interview, and record review, the facility failed to provide necessary care and services for two of six sampled residents (Resident 22 and Resident 100) by failing to: 1. Ensure call light (communication device used by residents to enable them to call for help from staff) was answered in a timely manner when Resident 22 was complaining of pain and screaming for help. 2. Ensure Resident 100's call light was within reach and not clipped in the curtain when resident was asking for someone to help her. These failures had the potential to put Resident 22 and 100 at risk for delayed treatment and care which lead to not meeting their needs. Findings: 1.During a review of Resident 22's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, (total paralysis of the arm, leg, and trunk on the left side of the body following a stoke) muscle weakness, diabetes mellitus(DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), gout(inflammatory arthritis that causes pain and swelling in the joints), and heart failure(heart does not pump enough blood to meet body's needs). During a review of Resident 22's Minimum Data Set (MDS-a resident assessment tool), dated 1/10/2025, the MDS indicated the resident had an intact cognition (thought process) and required substantial/maximal assistance(helper does more than half the effort) with bed mobility, toileting hygiene, bathing, dressing, and personal hygiene. During a review of Resident 22's History and Physical (H&P), dated 11/6/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 22's Care Plan initiated 10/24/2024, the Care Plan indicated the resident had the potential for altered comfort / pain related to gout and neuropathy(disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet).The Care Plan goal indicated the resident will voice a level of comfort through the review date. The Care plan interventions included anticipating the resident's need for pain relief and responding to complaint of pain. During an observation in Resident 22's room on 2/11/2025, at 11:14 a.m., Resident 22 pressed his call light and complained of pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/11/2025, at 11:19 a.m. , in the hallway facing Resident 22's room, Licensed Vocational Nurse (LVN 11) was two doors away from Resident 22's room whose call light was on, sending off a sound and resident could be heard asking for help. Observed LVN 11was passing medications and Ignore Resident 22's call light. During an observation on 2/11/2025, at 11:33 and 1t 11:34 a.m., Resident 22 continued screaming for a nurse and no one had come in to offer assistance. During an observation on 2/11/2025, at 11:40 a.m. , Restorative Nursing Assistant (RNA1)entered Resident 22's room and talked to the resident. During an interview on 2/11/2025, at 11:43 a.m. with RNA 1, RNA 1 stated Resident 22 was complaining of pain and had notified LVN 11 to come and see the resident. RNA1 stated everyone is responsible in answering residents' call light and call light should be answered as soon as possible to ensure their basic needs are met. During an interview on 2/13/2025, at 11:34 a.m. and subsequent interview and record review of Resident 22's Medication Administration Record (MAR- daily documentation record used by a licensed nurse to document medications and treatments given to a resident) on 2/15/2025, at 2:33 p.m.with LVN 11 , LVN 11 stated she administered Norco (medicine used to treat pain) on 2/11/2025, at 11:46 a.m. for a pain level of 7(numerical rating of pain of 7 indicated severe pain)because the resident was complaining of generalized pain(widespread pain that affects multiple areas of the body) after RNA 1 told her to come and see Resident 22 for complaint of pain. LVN 11 stated on 2/11/2025 at she did not see or hear the call light going off from Resident 22's room or hear resident's scream for help. LVN 11 stated everyone is responsible in answering the call light and call light should be answered immediately to ensure residents' pain was addressed. 2.During a review of Resident 100's Admission Record, the Admission Record indicated the resident was admitted on [DATE] to the facility with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side ((total paralysis of the arm, leg, and trunk on the same side of the body following a stroke), unspecified dementia (a progressive state of decline in mental abilities), and contracture of right elbow(a stiffening/shortening at any joint, that reduces the joint's range of motion). During a review of Resident 100's History and Physical (H&P), dated 1/30/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 100's Care Plan initiated 12/23/2024, the Care Plan indicated the resident had an increased risk for falls due to dementia, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, difficulty in walking , and right arm contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). The Care Plan goal indicated the resident would understand the importance of seeking assistance to help reduce the risk for falls. The Care Plan interventions included attempting to anticipate and meet resident's needs and encouraging the resident to use the call light for assistance as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/13/2025, at 3:14 p.m. in Resident 100's room with Licensed Vocational Nurse (LVN 13),LVN 13 verified call light of Resident 100 was clipped in the curtain and not within reach of the resident. LVN 12 agreed the call light should not be clipped in the curtain and should be within reach of the resident. During an interview on 2/14/2025, at 10:21 a.m. with CNA 6, CNA 6 stated call light should not be clipped in the curtain and should be within reach of the resident, CNA 6 stated the resident could be at risk for fall or accident if the call light is not available or not within reach. During an interview on 2/15/2025, at 3:01 p.m. with Director of Staff Development(DSD), DSD stated the staff is \expected to answer the call lights promptly and everyone is responsible in ensuring call lights are answered in a timely manner. DSD stated call lights should be within reach and should not be clipped to the curtain because the staff would not know if the resident needs assistance. DSD stated not answering the call light in a timely manner could cause unrelieved pain for Resident 22 and a delay of care for Resident 100. During an interview on 2/15/2025, at 7:24 p.m. with Chief Clinical Officer (CCO), CCO stated call light should be answered within 3 to 5 minutes to make sure resident needs will be met because the resident could be having pain that needs emergent attention. CCO stated the call light should not be clipped to the curtain and should be within the reach of the resident so they can use it to call for assistance, CCO stated residents might want to get up without help and this could lead to fall. During a review of facility's policy and procedure (P&P) titled Quality of Care, revised 11/6/2024, the P&P indicated the facility will ensure the residents will receive the appropriate treatment and care aligned with their personal preferences, care goals, and professional practice guidelines to meet their physical, mental and psychosocial needs. During a review of facility's P&P titled Use of Call lights reviewed 11/2016, the P&P indicated the staff will answer call lights in a timely manner, in a calm, courteous manner and whether or not the staff is assigned to the resident.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49889 Based on observation, interview and record review, the facility failed to ensure a resident did not develop a Stage II (partial-thickness loss of skin, presenting as a shallow open sore or wound) pressure injury (a localized pressure related damage to the skin and or underlying tissue) to sacrococcyx (bones at the base of the spine) area which progressed to a Stage IV (wound that penetrate all layers of skin exposing muscles, tendons [tissue that unites a muscle with a bone] cartilage {tissue that lines a joint}, and bones caused by prolonged pressure on the skin) pressure injury for one of one sampled residents (Resident 36). The facility failed to: 1. Ensure Resident 36 received treatment to a Stage II sacrococcyx pressure injury for 14 days from 11/8/2024-11/21/2024 as ordered by the physician. 2. Ensure Treatment Nurse (TX) assessed Resident 36 sacrococcyx pressure injury on weekly basis from 10/13/2024 to 12/12/2024 to prevent Resident 36's pressure injury from getting worse from Stage II to Stage IV. 3. Ensure the licensed nurses conducted weekly Resident 36's sacrococcyx pressure injury assessment per Care Plan titled, Resident has the potential for pressure injury development revised 1/7/25. and report any abnormal findings to Resident 36's physician. 4. Ensure Interdisciplinary Team ([IDT] - a coordinated group of staff from different fields who work together toward a common goal) recommendation for Registered Dietician ([RD]-certified healthcare professional who specializes in nutrition) consultation was completed in a timely manner. 5. Ensure staff followed the facility policy and procedure (P&P) titled, Wound Care Suggestions and Documentation, dated 10/2021 which indicated wounds should be measured and reviewed weekly for improvement or decline. The wound will be observed for improvement or decline with dressing changes and treatment orders will be changed accordingly. These failures resulted in Resident 36's developing a sacrococcyx Stage II pressure injury which progressed to a Stage IV pressure injury. Findings: During a review of Resident 36's Admission Record, dated 2/16/25 the Admission Record indicated Resident 36 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including persistent vegetative state (a condition in which a person is awake but lacks awareness of themselves of their surroundings) chronic respiratory failure (condition where lungs cannot adequately exchange oxygen and carbon dioxide leading to low blood oxygen level), malignant neoplasm (cancer) of the trachea (windpipe), tracheostomy (an opening surgically created in the trachea) and gastrostomy tube ([G-tube] a thin, flexible tube surgically inserted into the stomach for administration of nutrition, hydration, and medication) in place. During a review of Resident 36's, History and Physical (H&P) dated 5/4/2024, the H&P indicated Resident 36 did not have the capacity to understand and make decisions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 36's, Change of Condition Evaluation ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) dated 8/21/2024, the COC Evaluation indicated Resident 36 developed a Stage II pressure injury on the sacrococcyx measuring 5.0 cm in length by 0.5 cm in width with surrounded moist and slightly macerated (prolonged exposure to moisture) skin. During a review of Resident 36's, Physician Order Summary Report dated 8/22/2024, the Physician Order Summary Report indicated the order to clean reopened Stage II pressure injury with Normal Saline ([NS]-cleansing solution), pat dry and apply Medihoney gel (used to treat a variety of wounds) cover with foam dressing (type of dressing) every day for 21 days. During a review of Resident 36's, Minimum Data Set ([MDS] - a resident assessment tool) dated 10/6/2024, the MDS indicated Resident 36 was in a persistent vegetative state/no discernible consciousness (shows evidence of consciousness). The MDS also indicated Resident 36 was totally dependent (helper does all the effort) on staff assistance with Activities of Daily Living ([ADLs]- activities such as hygiene, dressing and toileting a person performs daily. The MDS indicated Resident 36 was at risk for developing pressure injury, had a Stage II pressure injury, no Stage IV pressure injury, and no unstageable pressure injury (a type of pressure ulcer where the depth of the wound cannot be determined due to the presence of slough [dead tissue] or eschar [dead tissue]). The MDS indicated treatment included pressure reducing device for bed, turning/repositioning program, and application of non-surgical dressings (a type of wound dressing used on wounds that do not require surgical intervention). During a review of Resident 36's Braden Scale (assessment tool used to assess a resident risk of developing pressure injury) dated 10/8/2024, the Braden Scale indicated Resident 36 had a score of eleven (10-12 indicated a high risk of developing pressure injury). During a review of Resident 36's Skin and Wound Evaluation dated 10/13/2024 the Skin and Wound Evaluation indicated Resident 36 had a Stage II pressure injury to the coccyx acquired at the facility on 8/21/2024 in stable condition measuring 2.5 cm in length by 2.0 cm in width with 0.2 cm in depth, with a 100 percent (%) granulation tissue (pink fleshy tissue that forms in the healing process of wounds) and light serosanguinous (clear watery fluid and blood) drainage. During a review of Resident 36's Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Conference Record Skin dated 10/13/2024 the IDT Conference Record indicated Resident 36 had a Stage II sacrococcyx pressure injury. The IDT Conference Record indicated recommendations to turn and reposition the resident, provide wound treatment of cleanse with NS, pat dry, apply collagen powder (wound therapy agent used to accelerate the healing process) then apply Silvadene cream (used to prevent and treat wound infections), cover with dry dressing. IDT recommendation included to follow up with Registered Dietician (RD) for recommendation. During a review of Resident 36's Nutritional Risk Review dated 10/29/24 the Nutritional Risk Assessment indicated Resident 36 had a left buttocks and sacrum ([tail bone] referring to the sacrococcyx) pressure injury. The Nutritional Risk Review indicated RD recommended to change Resident 36's G-tube feeding formula of Diabetisource AC from 50 milliliter ([ml]-unit of measurement) for 20 hours to 65 ml per hour for 20 hours. Resident 36's physician was notified but deferred RD recommendation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 36's, Physician Order Summary Report dated 11/4/2024, the Physician Order Summary Report indicated Resident 36 had treatment order for Stage II pressure injury on sacrococcyx to cleanse with NS, pat dry, apply collagen powder then apply Silvadene cream cover with dry dressing x 21 days with a start date 11/5/24 and discontinued on 11/7/24 with no documentation as to why it was discontinued. During a review of Resident 36's , Treatment Administration Record (TAR) for the month of 11/2024 , the TAR indicated Resident 36 stopped receiving wound treatment (TX) to Stage II sacrococcyx pressure injury from 11/8/2024 until 11/21/2024, with no documentation to indicate the reason the pressure injury treatment was discontinued and the treatment with Zinc Oxide (medication used to treat wounds) ointment apply to sacrococcyx one time a day for skin maintenance for 21 days was started on 11/22/24. During a review of Resident 36's Care Plan titled, Resident has the potential for development of a pressure injury related to incontinence and dependency on staff for repositioning due to persistent vegetative state dated 1/28/2022 and revised on 1/7/25, the Care Plan indicated the goal for Resident 36 was not to develop avoidable Stage III (full-thickness loss of skin, dead and black tissue may be visible) or Stage IV pressure injury. The Care Plan interventions included weekly skin inspections by licensed nurse, skin inspection during ADL's and report any abnormal findings to the medical doctor (MD), and RD if indicated for nutritional review to promote pressure injury healing. During a review of Resident 36's Care plan titled, Resident has an actual Stage IV to coccyx, at risk for worsening, dated 5/31/2022 and revised on 1/9/2025, the Care Plan indicated goal for the resident was to show evidence of responding to a pressure injury treatment. The Care Plan interventions included to administer pressure injury treatments as ordered and observe for treatment effectiveness, report to physician as needed any changes in skin status appearance, color, odor, wound healing, signs and symptoms of infection, wound size, and stage of the wound. During a review of Resident 36's, COC dated 12/12/2024, the COC indicated Resident 36 had a sacrococcyx unstageable pressure injury measuring 3.0 cm in length by 1.0 cm in width with unstageable tissue damage ([UTD] a full-thickness skin loss where the extent of tissue damage is unknown)). During a review of Resident 36's IDT Conference Record Skin dated 12/12/2024, the IDT Conference Record Skin indicated Resident 36 had sacrococcyx unstageable pressure injury on 12/12/2024. The IDT Conference Record indicated the pressure injury treatment included to cleanse pressure injury with NS, pat dry, apply collagen powder then apply Silvadene cream, cover with dry dressing. During a review of Resident 36's Skin and Wound Evaluation dated 12/14/2024, the Skin and Wound Evaluation indicated Resident 36 had a facility acquired unstageable pressure injury on the sacrococcyx area developed on 12/11/2024 and was measuring 4.5 cm in length by 3.0 cm in width and 1.5 cm in depth. The Skin and Wound Evaluation indicated Resident 36's sacrococcyx pressure injury was re-assessed as Stage III pressure injury on 12/19/2024 by in-house nurse (unknown). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 36's Physician Order Summary Report dated 12/17/2024, the Physician Order Summary Report indicated Resident 36 had orders for a treatment to sacrococcyx unstageable pressure injury, cleanse with NS, pat dry, apply Collagen Powder then apply Silvadene cream cover with dry dressing for 21 days with a start date 12/17/2024 and was discontinued on 12/18/24. The Physician Order Summary Report also indicated on 12/19/24 Resident 36 had an order to clean sacrococcyx pressure injury with NS, pat dry, apply Silvadene cream and Collagen Powder and Calcium Alginate (absorbs moisture and promotes healing) then cover with dry dressing daily for 21 days and discontinue on 12/26/24. The Physician Order Summary Report indicated on 12/27/24 an order for wound consult for Resident 36's pressure injury to the sacrococcyx. The Physician Order Summary Report dated 12/27/2024 indicated and order to cleanse sacrococcyx pressure injury with NS, pat dry, apply Medihoney gel then cover with dry dressing daily for 21 days. During a review of Resident 36's Wound Consultant Progress note dated 1/1/2025, the Wound Consultant Progress Note indicated Resident 36 had a sacrococcyx Stage IV pressure injury measuring 4.0 cm in length by 1.5 cm in width with 0.2 cm in depth. The Wound Consultant Progress note indicated wound debridement (a medical procedure that involves removing dead or infected tissue from a wound) was done at bedside. Wound Consultant Progress note indicated removed necrotic (dead tissue) subcutaneous (under the skin) tissue, muscle tissue and viable surrounding tissue to the point of bleeding. During a review of Resident 36's Nutritional Risk Review dated 1/6/2025 the Nutritional Risk Assessment indicated Resident 36 had a Stage IV pressure injury to the sacrococcyx area with recommendations to start Resident 36 on ProStat SF (liquid protein supplement) 30 two times a day and Juven (supplement to promotes wound healing) one packet two times a day to aid in wound healing. During an observation on 2/14/2025 at 7:25 a.m. in Resident 36's room, observed Treatment Nurse (TX) 1 providing treatment with Silvadene cream and Collagen Powder to Resident 36's Stage IV sacrococcyx pressure injury as ordered. During a concurrent interview and record review on 2/15/2025 at 1:40 p.m. with TX 1, Resident 36's Skin and Wound Evaluations dated 10/13/2024 and 12/14/2024 and Change of Conditions (COC) dated 8/21/2024 and 12/12/2024were reviewed. TX 1 stated that on 8/21/2024 Resident 36 was identified to have a Stage II pressure injury to sacrococcyx measuring 5.0 cm in length by 0.5 cm in width and was superficial. TX 1 stated on 10/13/2024 Resident 36 had a weekly skin evaluation done and Resident 36 sacrococcyx pressure injury measured 2.5 cm in length by 2.0 cm in width with 0.2 cm in depth with 100% granulation tissue. TX 1 stated on 12/12/2024 (two months after the last skin and wound evaluation) Resident 36 had a COC complete identifying an unstageable pressure injury on the sacrococcyx. TX 1 stated the next Resident 36 Skin and Wound Evaluations was done on 12/14/2024 and the resident had an unstageable pressure injury to the sacrococcyx measuring 3.0 cm in length by 1.5 cm in depth with undetermined depth and slough (dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds) present. TX 1 stated there was no other Resident 36's weekly Skin and Wound Evaluations documented to track the progression of Resident 36's pressure injury. TX 1 stated it was important to assess Resident 36's pressure injury to monitor Resident 36's pressure injury as it could change, and wound could deteriorate. TX 1 stated it was important to ensure pressure injury was assessed and monitored to ensure appropriate treatment was implemented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/15/2025 at 10:38 a.m. with Unit 2 Director of Nurses (UDON) 2, Resident 36's Skin and Wound Evaluations and Treatment Administration Record (TAR) were reviewed. UDON 2 stated that on 11/7/2024 treatment for the sacrococcyx Stage II pressure injury was discontinued with no documented reason for discontinuance. UDON 2 stated Resident 36 did not receive pressure injury treatment from 11/8/2024 through 1/21/2024. UDON 2 stated on 11/22/2024 the maintenance treatment with Zinc Oxide ointment application to sacrococcyx daily for 21 days was started but there was no documentation as to why the treatment was started. UDON 2 stated the last Resident 36's Skin and Wound Evaluations evaluation was done on 10/13/2024 indicating the resident had a Stage II sacrococcyx pressure injury measured 2.5 cm in length by 2.0 cm in width with 2.0 cm in depth with 100% granulation tissue in stable condition. UDON 2 stated the next Resident 36's pressure injury evaluation was done on 12/14/2024 and the resident had developed a sacrococcyx unstageable pressure injury measure at 3.0 cm in length by 1. 5 cm in depth with undetermined and slough present. UDON 2 stated pressure injury needs to have weekly assessment and documentation to track the progress of pressure injury healing. UDON 2 stated Resident 36's pressure injury was avoidable if Resident 36 sacrococcyx pressure injury was assessed, monitor and appropriate treatment was implemented timely. During a phone interview on 2/15/2024 at 12:06 p.m. TX 2 stated Resident 36 had a scar (permanent mark on the skin as a result from an injury or wound) on her sacrococcyx that started as moisture associated skin damage ([MASD] caused by prolonged exposure to moisture) (unknown date). TX 2 stated the Wound Coordinator (WC) was responsible for assessing and documenting Resident 36's pressure injury. TX 2 stated pressure injury can deteriorate when not assessed, and monitored so appropriate treatment can be implemented to avoid progression of pressure injury. During a concurrent interview and record review on 2/15/2025 at 4:23 p.m. with the Minimum Data Set Coordinator ([MDSC]), Resident 36's IDT Care Conferences dated 12/12/2024, and Resident 36's Care Plans dated 1/28/2022 and 1/7/2025 were reviewed. The MDSC stated all pressure injuries need to have weekly assessment and documentation including a weekly IDT Care Conference to track the healing progress of a pressure injury as it could improve or deteriorate. The MDSC stated the only IDT Care Conference that had been done for Resident 36 was on 10/13/2024 and on 12/12/2024. The MDSC stated Care Plans are a guide for the licensed nurses when providing care to the residents and need to be followed. The MDSC stated any time there was a change in the resident's condition a care plan needs to be reviewed and updated to reflect the level of care the resident is receiving. The MDSC stated there was a potential for an adverse reaction when resident's (in general) pressure injury was not assessed regularly, and nurses were not following the plan of care. During a concurrent interview and record review on 2/15/2025 at 4:23 p.m. with the RD, Resident 36's IDT notes dated 10/13/24 and 12/12/24 were reviewed. The RD stated the IDT recommendation for RD consult were made on 10/13/24 but were completed on 10/29/2024, two weeks later. The RD stated the IDT recommendation made on 12/12/2024 was not completed until 1/6/2025. RD stated all residents with pressure injuries should have RD's assessment done right away (unspecified). RD stated it was important to have RD recommendations to ensure pressure injury would heal as quick as possible as we don't want the pressure injury to get worse. RD stated, we want the pressure injury to get better, and without proper nutrition and the right supplements pressure injury can deteriorate. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/15/24 at 2:42 p.m. the Director of Nursing (DON) stated she was aware of Resident 36's Stage IV pressure injury to sacrococcyx developed on 12/12/2024. The DON stated she identify a systemic issue of the WC's lack of weekly pressure injury assessment documentation. The DON stated, there was a potential for harm to Resident 36 when weekly pressure injury assessment was not done, care plans were not followed, and pressure injury treatments not provided to Resident 36. The DON stated Resident 36's pressure injury deteriorated because weekly assessments were not being done to assess and monitor progress of pressure injury toward healing. The DON stated, pressure injury was avoidable if the right interventions were implemented. During a review of the facility's policy & procedures (P&P) titled Wound Care Suggestions and Documentation dated 10/2021, indicated, wounds should be measured and reviewed weekly for improvement or decline. The wound will be observed for improvement or decline with dressing changes and treatment orders will be changed accordingly. The physician should be notified of any improvements or decline that necessitates changes in order or to update. The primary care provider and family notification of wound care shall be documented in the appropriate section in the chart. Care plans are updated accordingly to reflect current interventions for wounds and the long-term interventions to prevent further breakdown as appropriate. Assessment-Elements and documentation Each wound a resident has shall be documented on admission, upon discovery, and at least weekly thereafter until healed.

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NAME OF PROVIDER OR SUPPLIER: Sunnyside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 22617 So. 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49145 Based on interview and record review, the facility failed to ensure the resident, who was a high risk for falls and injuries, did not fall and sustain injury for one of three sampled residents (Resident 136). The facility failed to: 1. Ensure Certified Nurse Assistant (CNA 2) did not leave Resident 136 unsupervised in the bathroom to go to assist another resident. 2. Ensure CNA 2 followed the facility's policy and procedure (P&P) titled, Fall Prevention and Management Program dated 2/2025, which indicated the facility must ensure that each resident receives adequate supervision and assistive devices (devices that are designed to assist a person to perform a particular task) to prevent accidents. 3. Ensure staff followed Resident 136's care plan titled The resident is at risk for falls dated 9/27/2023 to anticipate and use of assistive device front wheel walker ([FWW] a mobility aid with two wheels on the front and two legs on the back) as needed. These deficient practices resulted in Resident 136 falling on the floor on 12/7/2024 at 11:45 a.m., while unattended in the bathroom. and sustaining an injury. On 12/9/2024 Resident 136 was transferred to a General Acute Care Hospital (GACH) for evaluation and treatment where the resident was diagnosed with fracture (broken bone) of multiple pubic rami (a pair of bone that form part of the lower pelvis, at the front of each hip bone) and acute to subacute (used to describe the duration and severity of a medical condition) thoracic 12 (T12) compression fracture (a fracture of the 12th thoracic vertebra (bones of the spine) in the middle back) Findings: During a review of Resident 136's Admission Record, the Admission Record indicated Resident 136 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including osteoporosis (a bone disease that causes bones to become weak and brittle [easy to break], making them more prone to fracture), kyphosis (curving of the spine that causes bowing or rounding of the back) hypertension (high blood pressure), and a history of falling. During a review of Resident 136's Care Plan titled, Resident at Risk for Falls dated 9/27/2023, the Care Plan indicated the goal for Resident 136 was to reduce the risk for falls through the next review date (10/21/2024). The Care Plan's interventions including to anticipate and meet Resident 136's needs and encourage use of call light (a device that patients use to communicate with healthcare staff). During a review of Resident 136's Care Plan titled Activities of Daily Living (ADL daily self-care activities) self-care performance deficit dated 9/27/2023, the Care Plan interventions indicated staff will provide maximal assistance to Resident 136 with ADL as needed. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

During a review of Resident 136's Fall Risk Assessment (a comprehensive evaluation to identify factors that may increase a resident's risk of falling), dated 10/25/2024, indicated a score of 65 (a score above 45 on the Fall Risk Assessment indicated high risk for falls). The Fall Risk Assessment indicated Resident 136 was overestimating his/her abilities and was forgetting of her limitations. The Fall Risk Assessment indicated Resident 136's gait (how a person walk) was weak.

During a review of Resident 136's Nurses Progress Notes dated 12/7/2024 timed at 11:45 a.m., the Nurses Progress Notes indicated Resident 136 was found on the floor in a fetal position (laying on the side with knees bent and curled up toward the chest) in the bathroom's doorway. The Nurses Progress Notes indicated Resident 136 stated she fell backwards while trying to kick the bathroom door shut. The Nurses Progress Notes indicated Licensed Vocational Nurse (LVN-unknown) informed Resident 136 that she might be sent to GACH but Resident 136 declined.

During a review of Resident 136's Minimum Data Set ([MDS]- a resident assessment tool) dated 12/9/2024, the MDS indicated Resident 136's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 136 required substantial/maximal assistance (helper does more than half the effort) with showering, bathing, and lower body dressing and partial/moderate assistance (helper does less than half the effort) with toileting, personal hygiene, and upper body dressing. The MDS indicated Resident 136 required moderate assistance with walking 10 feet ([ft]-unit of measurement) but walking 50 ft to 150 ft was not attempted due to safety concerns. The MDS indicated the resident used FWW for walking. The MDS indicated Resident 136 was occasionally incontinent (inability to control bladder (urine) and bowel (stool) functions) of urine and bowel.

During a review of Resident 136's Nurses Progress Notes dated 12/9/2024 timed at 1:19 a.m., the Nurses Progress Notes indicated Resident 136 complained of bilateral (both) hips pain rated 10 out of 10 on a zero to ten pain rating scale (0 is no pain and 10 is worse possible pain). The Nursing Progress Note indicated Resident 136 was transferred to the GACH on 12/9/2024 at 1:19 a.m.

During a review of Resident 136's Interdisciplinary Team ([IDT]- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) Notes dated 12/9/2024 timed at 7:56 a.m., the IDT notes indicated on 12/7/2024, CNA 2 assisted Resident 136 to the bathroom . When Resident 136 was finished, she attempted to ambulate back to bed using her FWW . The IDT notes indicated Resident 136 attempted to kick the closed bathroom door, lost her balance and fell to the floor. The IDT Note indicated Resident 136 declined to go to GACH and refused Xray (imaging that produces pictures of the inside of the body) of the pelvis (hip) and leg initially. The IDT note indicated Resident 136 eventually agreed with the Xray of the pelvis on 12/8/2024, which indicated the resident had a non-displaced fracture of the left inferior pubic rami (a pair of bones that form part of the lower pelvis, at the front of each hip bone).

During a review of Resident 136's GACH's Progress Notes dated 12/10/2024 and timed 4:45 p.m., the GACH's Progress Note indicated Resident 136's Computed Tomography ([CT]- an imaging test used to detect internal injuries) of the abdomen and pelvis done on 12/9/2024 at 8:09 a.m. indicated probable subacute (beginning to heal) fractures of the left superior and inferior pubic rami.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 136's GACH's Discharge Summary report dated 12/15/2024, the GACH's Discharge Summary report Resident 136 was diagnosed with fracture of multiple pubic rami and acute to subacute 12th thoracic vertebra (T12) in the middle back). The GACH's Discharge Summary report indicated Resident 136 received lumbar (lower back) epidural (injection given in the lower back that numbs the lower half of the body) injection on 12/13/2024 at 5:29 p.m. for pain management. The GACH's Discharge Summary indicated Resident 136 to receive acute physical therapy (aimed in the restoration, maintenance, and promotion of optimal physical function) and pain management. During an interview on 2/13/2025 at 1:40 p.m., CNA 2 stated Resident 136 was forgetful and tends to not call for assistance when she wants to get up. CNA 2 stated she assisted Resident 136 to the bathroom and instructed Resident 136 to call CNA 2 when she was done. CNA 2 stated she left Resident 136 by herself in the bathroom to provide an assistance to another resident (Resident 136's roommate) in the same room. CNA 2 stated when she left, Resident 136 got up, walked with her FWW to walk out of the bathroom. CNA 2 stated Resident 136 tried to kick the bathroom door and lost her balance. CNA 2 stated Resident 136's fall could have been prevented if she (CNA 2) would not have left the resident unattended in the bathroom. During an interview on 2/13/2025 at 2:05 p.m., Licensed Vocational Nurse (LVN) 9 stated CNA 2 should not have left Resident 136 unattended in the bathroom as Resident 136 was forgetful and tended not to call for assistance. LVN 9 stated Resident 136's fall was avoidable if CNA 2 did not leave Resident 136 unattended in the bathroom on 12/7/2024. During an interview on 2/13/2025 at 3:33 p.m., Registered Nurse (RN) 3 stated Resident 136 was forgetful and required assistance with ambulation. RN 3 stated CNAs should remain with a resident when assisting to the bathroom, especially to residents who were forgetful and required assistance with ambulation to prevent falls. RN 3 stated Resident 136's fall was preventable if CNA 2 did not leave Resident 136 unattended in the bathroom on 12/7/2024. During an interview on 2/13/2025 at 4:24 p.m., the Director of Staff Development (DSD) stated she was responsible for CNAs training which includes caring for forgetful and confused residents and fall prevention. The DSD stated CNAs should not leave residents unattended in the bathroom if they are forgetful because they could fall and sustain injury. During an interview on 2/13/2025 at 4:42 p.m., the Unit Director of Nursing (UDON) 3stated CNA 2 should not have left Resident 136 in the bathroom unattended. The UDON 3 stated Resident 136's fall was avoidable if CNA 2 did not leave Resident 136 unattended on 12/7/2024. During an interview on 2/13/2025 at 5:31 p.m., with Resident 136, Resident 136 stated that since her fall she was unable to walk. Resident 136 stated she had pain on her hip and lower back that keeps her from not sitting in the chair which made her feel sad. During a review of the facility's P&P titled, Fall Prevention and Management Program, dated 2/2025, the P&P indicated, To ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review, the facility failed to ensure that medication error rate was less than five percent (%). Ten medication errors out of 29 total opportunities contributed to an overall medication error rate of 34.48 % for four of six residents (Resident 129, 80, 12, 230) observed during medication administration (MedPass). The facility failed to ensure: 1. Resident 129's Amlodipine (a medication used to treat high blood pressure) 5.0 (five) milligrams ([mg] - a unit of measure for weight) powder from the crushed medication was mixed with water before administration and medication cup was rinsed with water to ensure resident received the full dose via gastrostomy tube ([GT] - a soft tube surgically inserted into the stomach to administer medications, fluids, and nutrition). 2. Resident 80 was reassessed for abnormal blood pressure (BP) values (systolic blood pressure [SBP- top number] and diastolic blood pressure [DBP - bottom number] measured in millimeters of mercury ([mm Hg] unit to measure pressure), when the prescriber's order included a parameter to determine when to hold or administer a BP medication to the resident. 3. Ensure Resident 12 was administered medication that included seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) medications, Phenytoin and Phenobarbital and an anticoagulant (blood thinner) medication Heparin, within 60 minutes of scheduled administration time in accordance with facility's policy and procedures titled, Medication Administration - General Guidelines. 4. Ensure Resident 230 was administered Metoclopramide (medication for nausea and vomiting) within 60 minutes of scheduled administration time in accordance with facility's policy and procedures titled, Medication Administration - General Guidelines. The deficient practice placed Residents 129, 80, 12, and 230, at risk to experience medication adverse reactions, and complications including a high blood pressure leading to stroke (damage to the brain from interruption of its blood supply), hospitalization , a possible death, the potential for GT clogging leading to discomfort/pain and GT replacement, uncontrolled seizures leading to possible brain damage and death. Findings: 1. During a review of Resident 129's Admission Record, the Admission Record indicated Resident 129 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (is a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (a stroke that occurs when blood flow to the brain is blocked) affecting left non-dominant (use consistently for task) side, hypertension (high blood pressure), with GT in place. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 129's, Minimum Data Set ([MDS] - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 129's cognitive skills (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) for daily decision-making were severely impaired. Resident 129's MDS indicated the resident was dependent on staff physical assistance for all Activities of Daily Living ([ADLs]- eating, bathing, or showering, dressing, getting in and out of bed or a wheelchair, toileting, and personal hygiene). During a review of Resident 129's, History and Physical (H&P) dated 1/11/2025, the H&P indicated Resident 129 did not have the capacity to understand and make decisions. During a review of Resident 129's, Physician Order Summary Report dated,1/8/2025 the Physician Order Summary Report indicated Resident 129 had the following orders: 1.Amlodipine (Norvasc) 5.0 mg to be given via GT one time a day, scheduled at 12:00 p.m., for hypertension, hold if SBP (pressure in the arteries when the heart contracts and pumps blood throughout the body) is less than 110 mmHg, ordered on 1/9/2025. 2. May crush crushable medication and mix with the appropriate vehicle (liquid or base in which a medication is mixed to be administered), ordered on 1/8/2025. During a review of Resident 129's, Care Plan titled Resident 129 had hypertension (HTN) and CVA dated 12/19/24, the Care Plan indicated a goal to implement interventions to assist the resident in achieving a blood pressure within normal limits. During a medication pass observation on 2/11/2025 at 1:20 p.m., the Licensed Vocational Nurse (LVN) 2, was observed crushing one tablet of Amlodipine 5.0 mg tablet and entered the Resident 129's room. LVN 2 was observed initially flushed GT with water and then poured directly into the GT the crushed Amlodipine tablet that was in a powder form. LVN 2 was observed to follow with GT final water flush. The medication cup was observed to have the residual of powdered Amlodipine along the walls and at the bottom. During an interview on 2/11/2025 at 1:42 p.m., with LVN 2, LVN 2 looked inside of Resident 129's medication cup that contained white powder and stated, the resident did not receive the full dose. LVN 2 stated she should have added water to the crushed Amlodipine prior to administering the medication through the GT and should have made sure Resident 129 was administered the full dose of medication. During an interview on 2/13/2025 at 9:27 a.m., with a Registered Nurse (RN) 1 and UDON 2 on Station 200, RN 1 stated that crushable medication should be mixed with 5.0 (five) ml of water to completely dissolve the medication before administering it via GT. RN 1 stated if medication residual (left over medication) is in the cup the licensed nurse must add more water to make sure all of the medication was administered to the resident to prevent under dosing of medication During a review of the facility's Policy and Procedure (P&P) titled, General Guidelines for Administering Medication via GT, dated 11/2021, the P&P indicated, The powder from each medication is mixed with water before administration. The souffle cup is rinsed with water to get all of the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 80's Admission Record, the Admission Record indicated Resident 80 was admitted on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (an infection that affects one or both lungs), Atrial fibrillation ([AFib]- is an irregular and often very rapid heartbeat), hypotension (low blood pressure), chronic (long-term) diastolic congestive heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). During a review of Resident 80's, MDS dated [DATE], the MDS indicated Resident 80's cognition was intact. The MDS indicated Resident 80 required substantial/maximal assistance (helper does more than half the effort) to total dependence (helper does all the effort) upon facility staff for ADLs. During a review of Resident 80's, Physician Order Summary Report dated 2/7/2025, the Physician Order Summary Report indicated Resident 80 had orders for: a. Amiodarone 200 mg, one tablet by mouth two times a day (9 a.m. and 5 p.m.) for coronary artery disease ([CAD] occurs when blood vessels that carry blood to the heart get blocked with plaque [fatty deposits]) hold if SBP is less than 110 mmHg, order start date 2/7/2025. b. Metoprolol (used to treat high blood pressure, 25 mg, give one half tablet (12.5 mg) by mouth two times a day (9 a.m. and 5 p.m.) for hypertension, hold if SBP is less than 90 or heart rate ([HR] the number of times your heart beats in a minute [bpm]) is less than 55 bpm, order start date 2/7/2025. c. Midodrine (medication used to treat low blood pressure) 10 mg, give one- and one-half tablet (15 mg) by mouth three times a day (9 a.m., 1 p.m., and 5 p.m.) for hypotension, hold if SBP is greater than 130 mmHg, order start date 2/7/2025. During a review of Resident 80's, Care Plan titled Resident 80 has altered cardiovascular (heart) status related to congestive heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), hypotension, dated 1/28/2025, the Care Plan interventions indicated, administer medications as ordered, observe for side effects and effectiveness, observe vital signs (include blood pressure, heart rate, respiration (breathing rate), body temperature, and oxygen saturation ([the percentage of oxygen in your blood] which are indicators of health status) as ordered and to notify medical doctor (MD) of significant abnormalities. During a review of Resident 80's ,Care Plan titled, Resident 80 has hypotensive heart disease, A-fib dated 1/16/2025, the Care Plan indicated the interventions included to observe vital signs, notify MD of significant abnormalities, observe/document/report to the MD as needed (PRN) any signs and symptoms of hypotension: dizziness, fainting, syncope, blurred vision, lack of concentration, nausea, fatigue, cold clammy pale skin, give medications as ordered and observe for side effects and effectiveness. During a concurrent medication pass observation and interview on 2/12/2025, between 8:42 a.m. to 9:08 a.m. , with LVN 1, on Station 200 at MedCart 200, the following was observed and interviews included: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. On 2/12/2025 at 8:42 a.m., LVN 1 stated that he was inputting vital signs into the computer that was taken by a Certified Nurse Assistant (CNA) 1. LVN 1 showed a handwritten paper with seven residents names and vital signs that included BP readings written on a piece of paper. 2. On 2/12/2025 at 8:47 a.m., LVN 1 was observed entering the pre-written vital signs into the computer that included BP reading for Resident 80 which indicated a BP of 84/44 mmHg (normal BP reference range is 120/80 to 129/79). 3. On 2/12/2025 at 8:50 a.m., LVN 1 stated he will hold (not administer) Resident 80's Amiodarone because Resident 80's SBP was less than 110 and he will hold Resident 80's Metoprolol because the Resident 80's SBP was less than 90 mmHg, and the heart rate was less than 55 bpm. LVN 1 was not observed checking or assessing Resident 80's BP or heart rate. During a concurrent observation and interview on 2/12/2025 at 9: 04 a.m., LVN 1 was asked to recheck Resident 80's BP. LVN 1 used an automated (automatic) BP machine. LVN 1 stated the Resident 80's BP was 104/52 mmHg. LVN 1 stated he will re-enter Resident 80's BP reading into the computer and will prepare and give Resident 80's BP medication of Metoprolol as the resident's SBP was within the parameter ordered by the physician to administer Metoprolol. During an interview on 2/12/2025 at 9:15 a.m., LVN 1 stated, We have to follow the parameters that the doctor set. LVN 1 stated that he would not know if Resident 80 had BP within the acceptable parameters for medication administration Metoprolol, Amiodarone, or Midodrine, if he did not recheck the resident's BP just before medication administration. LVN 1 stated that he did not know at what time CNA1 had checked Resident 80's BP. During an interview on 2/12/2025 at 1:20 p.m., CNA 1 stated she had seven assigned residents on 2/12/2025. CNA 1 stated she takes vital signs including BP every morning at about 7:30 a.m. and finished taking vital signs for all seven residents on 2/12/2025 by 8 a.m. CNA 1 stated she took Resident 80's BP twice because the BP reading was too low. CNA 1 stated she circled Resident 80's low BP on a paper given to LVN 1 so LVN 1 would know that Resident 80's BP reading was low and was taken twice. CNA 1 stated she had two residents with low BP, Resident 80 and Resident 511, and she circled the BP reading numbers for both Resident 80 and Resident 511. CNA 1 stated Resident 80's vital signs were written by her on the handwritten paper as followed: BP was 78/50 mmHg (first BP check) Temperature 97.5 Fahrenheit (F temperature scale) Heart Rate/Pulse 100 bpm Respiration Rate 18 Oxygen Saturation 94 percent (%) BP retaken and circled by CNA 1 was 84/44 mmHg According to the American Heart Association, dated 5/2024, hypotension, or low blood pressure, is defined as a blood pressure reading below 90/60 mmHg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	https://www.heart.org/ During an interview on 2/13/2025 at 9:35 a.m., with a Registered Nurse (RN) 1 and a Unit Director of Nursing (UDON) 2 on Station 200, RN 1 stated, it is the job of the charge nurse to check the vital signs including BP prior to medication administration, especially medications to control BP that have a parameter to determine when to give or not give the BP medication. UDON 2 stated the BP taken by CNAs in the morning was just to see how the residents were doing. UDON 2 stated, when it comes to administering medications the charge nurse must do their own BP check and monitoring. During a concurrent interview and record review on 2/13/2025 at 9:44 a.m., with RN 1 and UDON 2, Resident 80 and Resident 511's vital signs taken on 2/12/2025 in the morning by CNA 1 were reviewed. UDON 2 stated Resident 80's BP readings of 78/50 mmHg and 84/44 mmHg and Resident 511's BP reading of 88/55 and 86/52 were abnormal values. RN 1 stated administering BP medications to residents based on inaccurate BP readings could cause the resident to experience hypotension or hypertension. RN 1 stated the charge nurse cannot rely on the CNAs morning BP checks. RN 1 stated the charge nurse should evaluate and reassess the resident before making medication administration decisions. During a review of the facility's P&P titled, Vital Signs Monitoring Procedure, dated 2/2025, the P&P indicated, Nursing staff must document, report, and act on abnormal findings promptly .Vital Signs must be checked .Before and after medication administration (e.g., antihypertensives, cardiac drugs, and pain medications). During a review of the facility's P&P titled, Administration Procedures For All Medications, dated 6/2021, the P&P indicated, Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. 3. During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cerebral palsy (a group of disorders that affect movement, balance, and posture), and convulsions (a shaking movement of the body that cannot be controlled). During a review of Resident 12's, MDS dated [DATE], the MDS indicated Resident 12's cognition was moderately impaired. The MDS indicated Resident 12 required setup assistance for eating, oral and personal hygiene, and partial staff assistance for bathing or showering, dressing, and toileting. During a review of Resident 12's H&P dated 11/22/24 the H&P indicated Resident 12 had the capacity to understand and make decisions. During a review of Resident 12's, Physician Order Summary Report dated 11/7/2024, the Physician Order Summary Report indicated Resident 12 had orders for: a. Calcium (supplement) 500 mg plus Vitamin D, 5.0 micrograms ([mcg] unit of measure of weight) one tablet by mouth two times a day (9 a.m. and 5 p.m.) for supplement, ordered on 11/7/2024. b. Vitamin D 25 mcg (Cholecalciferol, 1000 International Units [IU, an internationally accepted amount of a substance]), one tablet by mouth one time a day (9 a.m.) for supplement, ordered on 11/7/2024. (continued on next page)

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 02/15/2025
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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Cyanocobalamin (B-12) 500 mcg, one tablet by mouth one time a day (9 a.m.) for supplement, ordered on 11/7/2024. d. Multivitamins with Minerals (One-Daily), one tablet by mouth one time a day (9 a.m.) for supplement, ordered on 11/7/2024. e. Tamsulosin ([Flomax] used to treat men with symptoms of an enlarged prostate) 0.4 mg, one capsule by mouth one time a day (9 a.m.) for obstructive uropathy (a condition in which the flow of urine is blocked), acute urinary retention (an inability to completely empty the bladder), ordered on 11/8/2024. f. Phenytoin (used to control seizures [convulsions]) extended release (long acting) 100 mg, one capsule by mouth two times a day (9 a.m. and 5 p.m.) for seizure disorder, ordered date 11/7/2024. g. Phenobarbital [used to control seizures] Oral Tablet 32.4 mg, one tablet by mouth one time a day (9 a.m.) for seizure disorder, ordered on 11/7/2024. h. Heparin (an anticoagulant, blood thinner) 5,000 units per ml per vial, inject one ml subcutaneously ([SQ] injection just under the skin), every 12 hours (9 a.m. and 9 p.m.) for deep vein thrombosis ([DVT] occurs when a blood clot [thrombus] forms in one or more of the deep veins in the body, usually in the legs), ordered on 11/7/2024. During a review of Resident 12's Care Plans titled, Resident 12 on anticoagulant therapy Heparin injection solution 5000 unit/ml, risk for bleeding and easily bruising, dated 11/26/2024, the Care Plan indicated the resident was at high risk for bruising and bleeding was a sign of anticoagulant medication overdose, The Care Plan interventions included to administer anticoagulant medications as ordered by the physician, observe for signs of bleeding, and report to MD if observed. During a review of Resident 12's, Care Plans titled Resident 12 has unspecified convulsions, high risk for trauma/injuries, dated 11/26/2024 the Care Plan indicated interventions included to give antiseizure medications as ordered observe/document for medication effectiveness and side effects. During a concurrent observation and interview on 2/12/2025 at 11:56 a.m., with LVN 3 on Station 400/500 MedCart, LVN 3 stated she was preparing Resident 12's morning medications scheduled for 9 a.m., administration. LVN 3 prepared the following medications for Resident 12: a. Calcium 500 mg plus Vitamin D 5.0 mcg, one tablet. b. Vitamin D 25 mcg (1000 IU), one tablet. c. Cyanocobalamin (B-12) 500 mcg, one tablet . d. Multivitamins with Minerals, one tablet. e. Tamsulosin 0.4 mg, one capsule. f. Phenytoin 100 mg, one capsule. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Phenobarbital Oral Tablet 32.4 mg, one tablet. h. Heparin 5,000 units per ml, one ml vial. During a concurrent observation and interview on 2/12/2025 at 12:20 p.m., LVN 3 stated she prepared a total of eight medications, seven tablets plus one injection. LVN 3 was observed entering Resident 12's room to administer the medications. During an interview on 2/12/2025 at 12:28 p.m., LVN 3 stated Resident 12 should have received 9 a.m., scheduled medication within one hour of the scheduled administration time. (9 a.m.). LVN 3 stated the physician should have been informed when Resident 12 was not administered his medications as scheduled. LVN 3 stated, I have not informed the doctor .I should have called the doctor before administering the medications late to Resident 12. LVN 3 stated administering Resident 12 medications late could cause the resident to have the adverse reactions, especially with the seizure medication, Phenytoin scheduled to be administered two times a day and the blood thinner Heparin scheduled to be administered every 12 hours. LVN 3 stated Resident 12's medications were not given in accordance with the physician's orders. During a review of Resident 12's, Medication Administration Record ([MAR] a written record of all medications given to a resident), the MAR dated 2/12/2025, indicated Resident 12 received the following morning medications scheduled for 9 a.m. on 2/12/2025 over 60 minutes after the scheduled time. Resident 12's MAR indicated Resident 12 received medications on 2/12/2025 as follows: a. Calcium 500 mg plus Vitamin D 5 mcg, scheduled for 9 a.m., documented administered at 11:51 a.m. (two hour and 51 minutes late). b. Vitamin D 25 mcg (1000 IU) scheduled for 9 a.m., documented administered at 11:51 a.m. (two hour and 51 minutes late). c. Cyanocobalamin (B-12) 500 mcg, scheduled for 9 a.m., documented administered at 11:51 a.m. (two hour and 51 minutes late). d. Multivitamins with Minerals, scheduled for 9 a.m., documented administered at 11:51 a.m. (two hour and 51 minutes late). e. Tamsulosin 0.4 mg, scheduled for 9 a.m., documented administered at 11:51 a.m. (two hour and 51 minutes late). f. Phenytoin 100 mg, scheduled for 9 a.m., documented administered at 12:16 p.m. (three hours and 16 minutes late). g. Phenobarbital Oral Tablet 32.4 mg, scheduled for 9 a.m., documented administered at 12:17 p.m. (three hour and 17 minutes late). h. Heparin 5,000 units per ml, scheduled for 9 a.m., documented administered at 12:26 p.m. (three hour and 26 minutes late). (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/2025 at 10:16 a.m., RN 2 stated the allowed window time to administer medications was one hour before or one hour after the scheduled administration time. RN 2 stated if the administration will be outside of the allowed window to administer medications the charge nurse should let the Director of Nursing (DON) know, or someone above them and notify the resident's physician. RN 2 stated the physician should be notified before the charge nurse administer the medication late and ask the physician to advise whether to give the medication or not and to follow the physician's instruction. RN 2 stated the charge nurse should notify the resident's responsible party if the resident is not able to speak for themselves. RN 2 stated the charge nurse must document the physician response and document that the resident and/or the resident's responsible party was notified. RN 2 stated giving Resident 12's seizure medications, Phenytoin and Phenobarbital could cause the resident to be overdosed because the medication may run too close to the next scheduled seizure medication dose. RN 2 stated Resident 12 could also be overdosed on the Heparin that should be given every 12 hours and if given less than 12 hours apart could cause an overdose of Heparin, which could lead to bleeding more easily, may cause the blood to thin too much and increase risk of bruising. During a concurrent interview and record review on 2/13/2025 at 10:37 a.m., with RN 2, Resident 12's Medication Administration Detail/Audit Report was reviewed. RN 2 stated Resident 12's medication scheduled for 9 a.m. administration on 2/12/2025 was administered after 12 p.m. on 2/12/2025. RN 2 stated the note to the physician was dated 2/12/2025 and timed after 5 p.m. RN 2 stated the nursing note created by date and time is based on the computer that indicated the physician was notified on 2/12/2025 at 5:26 p. m. after the resident had been administered the medications late. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration - General Guidelines, dated 11/2021, the P&P indicated, Medications are administered within (60 minutes) of scheduled time, except before or after meal orders, which are administered (based on mealtimes). 4. During a review of Resident 230's Admission Record, dated 2/15/25 the Admission Record indicated Resident 230 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing) following a cerebral infraction ([CVA-]stroke, loss of blood flow to a part of the brain), hypertension (high blood pressure), gastro-esophageal reflex (Gerd- indigestion) gastritis (inflammation of the stomach lining), and esophagitis (inflammation that damages the tube running from your throat to your stomach. During a review of Resident 230's, MDS dated [DATE], the MDS indicated Resident 230's cognition was intact. The MDS also indicated Resident 230 needed supervision/touch assistance with ADLs. During a review of Resident 230's, H&P dated 2/02/2025 the H&P indicated Resident 230 recognized/recalled daily routine without prompts or repetition. During a review of Resident 230's, Physician Order Summary Report dated 2/13/25, the Physician Order Summary Report indicated Resident 230 had orders for Metoclopramide (Reglan) 10 mg to be given via GT four times a day 8:00 a.m., 12:00 p.m., 4:00 p.m. , and 9:00 p.m. for nausea. During a review of Resident 230's, Medication Administration Audit Report (MAR) dated 2/11/2025, MAR indicated Resident 230 received her 8:00 a.m. dose at 9:16 a.m., 12:00 p.m. dose at 1:55 p.m., 4:00 p.m. dose at 6:18 p.m. and her 9:00 p.m. dose at 10:32 p.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 230's, MAR dated 2/12/25, the MAR indicated Resident 230's Metoclopramide dose at 8:00 a.m. dose received at 9:33 a.m., 12:00 p.m. dose at received at 1:52 p.m., 4:00 p.m. dose received at 7:28 p.m. and her 9:00 p.m. dose received at 10:29 p.m. During a review of Resident 230's, Care Plan titled, Resident 230 had an alteration in gastrointestinal status related to dysphagia, gastritis, and esophagitis, dated 2/03/25, the Care Plan interventions included to administer medications as ordered, observe for side effects and the effectiveness of the medications. During an interview on 2/11/25 at 1:15 p.m. with Resident 230, Resident 230 stated she just got a new GT placed in last week. Resident 230 stated she had a CVA and was not able to swallow very well. Resident 230 stated she has been getting all her medications and food through her GT and she has been having issues with the food digesting well. Resident 230 stated her MD started her on a new medication Metoclopramide to help with her nausea. Resident 230 stated the nurses have been late with her medications a few times. During an interview on 2/12/25 at 9:51 am. with Resident 230, Resident 230 stated she just got her 8:00 a.m. medications. Resident 230 stated she had just gotten use to her medications being late but feels she should get her medications on time because she needs to get better. During an interview on 2/11/25 at 1:32 p.m. LVN 9 stated she has an hour before and an hour after medication scheduled times that she could administer medications. LVN 9 stated she was late with giving Resident 230's 12:00 p.m. medication today because she was very busy and had a lot of work and was running behind. LVN 9 stated Resident 230 needed her Metoclopramide medication to prevent nausea. During a concurrent interview and record review on 2/14/25 at 1:22 p.m. with LVN 1, Resident 230's MAR dated 2/12/25 was reviewed, the MAR indicated Resident 230 received her 8:00 a.m. Metoclopramide dose at 9:33 a.m., 12:00 p.m. dose at 1:52 p.m., 4:00 p.m. dose at 7:28 p.m. and her 9:00 p.m. dose at 10:29 p.m. LVN 1 stated he worked 16 hours on 2/12/2025 and took care of Resident 230 from 7:00 a.m. to 11:00 p.m. LVN 1 stated he was late with giving Resident 23's scheduled Metoclopramide doses and that he knows medication needed to be given at the scheduled times. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration - General Guidelines, dated 11/2021, the P&P indicated, Medications are administered within (60 minutes) of scheduled time, except before or after meal orders, which are administered based on mealtimes. 45269 49889

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NAME OF PROVIDER OR SUPPLIER Sunnyside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22617 So. Vermont Ave Torrance, CA 90502	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on interview and record review the facility failed to ensure one out of six sampled residents (Resident 12) was free of a significant medication error. The facility failed ensure Resident 12 was administered medication that included seizure (convulsions, is a sudden rush of abnormal electrical activity in your brain) medications, Phenytoin and Phenobarbital and an anticoagulant (blood thinner) medication Heparin was administered as ordered and not close to the next scheduled dose for Phenytoin and Heparin. (Cross reference: F759) The deficient practice of failing to administer medications in accordance with the physician orders increased the risk that Residents 12 may experience adverse reactions, complications, that could lead to a decline in the residents' condition, harm, or hospitalization . Findings: During a review of Resident 12's Admission Record, the Admission Record indicated Resident 12 was admitted to the facility on [DATE] and readmitted [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cerebral palsy (a group of disorders that affect movement, balance, and posture), and convulsions (a shaking movement of the body that cannot be controlled). During a review of Resident 12's, Minimum Data Set (MDS-resident assessment tool) DS dated 11/14/2024, the MDS indicated Resident 12's cognition (conscious mental activities including thinking, reasoning, understanding, learning, and remembering) was moderately impaired. The MDS indicated Resident 12 required setup assistance for eating, oral and personal hygiene, and partial staff assistance for bathing or showering, dressing, and toileting. During a review of Resident 12's, History and Physical (H&P) dated 11/22/24 the H&P indicated Resident 12 has the capacity to understand and make decisions. During a review of Resident 12's, Physician Order Summary Report dated 11/7/2024, the Physician Order Summary Report indicated Resident 12 had orders for: a. Phenytoin (used to control seizures [convulsions]) extended release (long acting) 100 milligram (mg-unit of measurement), one capsule by mouth two times a day (9 a.m. and 5 p.m.) for seizure disorder, ordered date 11/7/2024. b. Phenobarbital (used to control seizures) oral tablet 32.4 mg, one tablet by mouth one time a day (9 a.m.) for seizure disorder, ordered on 11/7/2024. c. Heparin (an anticoagulant, blood thinner) 5,000 units per milliliter (ml -unit of measurement) ml per vial, inject one ml subcutaneously ([SQ] injection just under the skin), every 12 hours (9 a.m. and 9 p.m.) for deep vein thrombosis ([DVT] occurs when a blood clot [thrombus] forms in one or more of the deep veins in the body, usually in the legs), ordered on 11/7/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Sunnyside Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 22617 So. Vermont Ave Torrance, CA 90502	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's Care Plans titled, Resident 12 on anticoagulant therapy Heparin injection solution 5000 unit/ml, risk for bleeding and easily bruising, dated 11/26/2024, the Care Plan indicated the resident was at high risk for bruising and bleeding was a sign of anticoagulant medication overdose, The Care Plan interventions included to administer anticoagulant medications as ordered by the physician, observe for signs of bleeding, and report to MD if observed. During a review of Resident 12's, Care Plans titled Resident 12 has unspecified convulsions, high risk for trauma/injuries, dated 11/26/2024, the Care Plan indicated interventions included to give antiseizure medications as ordered observe/document for medication effectiveness and side effects. During a concurrent observation and interview on 2/12/2025 at 11:56 a.m., with LVN 3 on Station 400/500 Med Cart, LVN 3 stated she was preparing Resident 12's morning medications scheduled for 9 a.m., administration. LVN 3 prepared the following medications for Resident 12: a. Phenytoin 100 mg, one capsule b. Phenobarbital Oral Tablet 32.4 mg, one tablet c. Heparin 5,000 units per ml, one ml vial During an observation and interview on 2/12/2025 at 12:20 PM, with LVN 3, LVN 3 entered Resident 12's room and administer the prepared medications. During an interview on 2/12/2025 at 12:28 p.m., LVN 3 stated Resident 12 should have received 9 a.m., scheduled medication within one hour of the scheduled administration time. (9 a.m.). LVN 3 stated the physician should have been informed when Resident 12 was not administered his medications as scheduled. LVN 3 stated, I have not informed the doctor .I should have called the doctor before administering the medications late to Resident 12. LVN 3 stated administering Resident 12 medications late could cause the resident to have the adverse reactions, especially with the seizure medication, Phenytoin scheduled to be administered two times a day and the blood thinner Heparin scheduled to be administered every 12 hours. LVN 3 stated Resident 12's medications were not given in accordance with the physician's orders. During a review of Resident 12's, Medication Administration Record (MAR, a written record of all medications given to a resident)/ Medication Administration Audit Report indicated Resident 12's MAR indicated Resident 12 received medications on 2/12/2025 as follows: a. On 2/12/2025 Phenobarbital 32.4 mg, scheduled for 9 a.m., documented administered at 12:17 p.m. (three hours and 17 minutes late) b. On 2/7/2025 Phenobarbital 32.4 mg, scheduled for 9 a.m., documented administered at 11:36 a.m. (two hours and 36 minutes late). c. On 2/12/2025 Phenytoin 100 mg, scheduled for 9 a.m., documented administered at 12:16 p.m. (three hours and 16 minutes late). d. On 2/12/2025 Phenytoin 100 mg, scheduled for 5 p.m., documented administered at 4:00 p.m., less than four hours after the morning medication was administered late. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 2/7/2025 Phenytoin 100 mg, scheduled for 9 a.m., documented administered at 11:32 a.m. (two hours and 32 minutes late). f. On 2/7/2025 Phenytoin 100 mg, scheduled for 5 p.m., documented administered at 4:07 p.m., about four hours after the morning medication was administered late g. On 2/12/2025 Heparin 5,000 units per ml, scheduled for 9 a.m., documented administered at 12:26 p.m. (three hour and 26 minutes late). h. On 2/12/2025 Heparin 5,000 units per ml, scheduled for 9 p.m., documented administered at 8:00 p.m., seven hours and 34 minutes after the morning medication was administered late, and not in accordance with physician order to administer heparin every 12 hours. i. On 2/7/2025 Heparin 5,000 units per ml, scheduled for 9 a.m., documented administered at 11:36 a.m. (two hours and 36 minutes late) j. On 2/7/2025 Heparin 5,000 units per ml, scheduled for 9 p.m., documented administered at 8:04 p.m., seven hours and 38 minutes after the morning medication was administered late, and not in accordance with physician order to administer heparin every 12 hours. During an interview on 2/13/2025 at 10:16 a.m., Registered Nurse (RN) 2 stated the allowed window time to administer medications was one hour before or one hour after the scheduled administration time. RN 2 stated if the administration will be outside of the allowed window to administer medications the charge nurse should let the Director of Nursing (DON) know, or someone above them and notify the resident's physician. RN 2 stated the physician should be notified before the charge nurse administer the medication late and ask the physician to advise whether to give the medication or not and to follow the physician's instruction. RN 2 stated the charge nurse should notify the resident's responsible party if the resident is not able to speak for themselves. RN 2 stated the charge nurse must document the physician response and document that the resident and/or the resident's responsible party was notified. RN 2 stated giving Resident 12's seizure medications, Phenytoin and Phenobarbital could cause the resident to be overdosed because the medication may run too close to the next scheduled seizure medication dose. RN 2 stated Resident 12 could also be overdosed on the Heparin that should be given every 12 hours and if given less than 12 hours apart could cause an overdose of Heparin, which could lead to bleeding more easily, may cause the blood to thin too much and increase risk of bruising. During a concurrent interview and record review on 2/13/2025 at 10:37 a.m., with RN 2, Resident 12's Medication Administration Detail/Audit Report was reviewed. RN 2 stated Resident 12's medication scheduled for 9 a.m. administration on 2/12/2025 was administered after 12 p.m. on 2/12/2025. RN 2 stated the note to the physician was dated 2/12/2025 and timed after 5 p.m. RN 2 stated the nursing note created by date and time is based on the computer that indicated the physician was notified on 2/12/2025 at 5:26 p. m. after the resident had been administered the medications late. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, dated 11/2021, the P&P indicated, Medications are administered in accordance with written orders of the attending physician .Medications are administered within (60 minutes) of scheduled time, except before or after meal orders, which are administered (based on mealtimes). (continued on next page)

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Sunnyside Nursing Center	22617 So. Vermont Ave Torrance, CA 90502

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cross reference F759

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333 Based on observation, interview, and record review the facility failed to ensure: 1. One of four medications carts (Station 300 [NAME] Medication Cart (Med Cart) 2 was locked when not attended by the Licensed Vocational Nurse (LVN) 2. This failure had the potential to result in visitors, residents, and staff unauthorized access to residents' medications. 2. One of two medication cart (Station Subacute Med Cart Red Zone) inspected which contained home medications (medications brought to the facility by a resident or family member) that included a controlled medication, Lorazepam (used to treat anxiety [emotion characterized by feelings of tension, worried thoughts] disorders) ,labeled for Resident 390 was not stored inside of Station Subacute Med Cart Red Zone without a physician order for the resident. This failure of storing Lorazepam which was not a medication ordered by Resident 390's physician in Med Cart Red Zone increased the risk for medication misuse, drug diversion (when a medication is taken for use by someone other than whom it is prescribed), medication errors, and/ or resident harm. 3. Resident 25's Ipratropium-Albuterol Inhalation Solution (used to help control the symptoms of lung diseases) had an open date. This failure had the potential to result in Resident 28 receiving medication that had become ineffective or toxic due to improper storage possibly leading to health complications or hospitalization . Findings: 1. During a medication pass observation on [DATE] at 12:35 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 after preparing medications for Resident 169, LVN 2 left Med Cart 2 in the hallway unlocked and entered Resident 169's room and closed the resident's privacy curtain. Med Cart 2 was observed in the hallway unattended, unlocked and out of the view of LVN 2. During a concurrent observation and interview on [DATE] at 12:37 p.m., Registered Nurse (RN) 1, noticed the unlocked medication cart while LVN 2 was behind Resident 169's privacy curtain and pushed the button to lock Med Cart 2. RN 2 stated, the medication cart should have been locked. During an interview on [DATE] at 1:43 p.m., with LVN 2, LVN 2 stated the medication cart should have been completely closed, shut and locked to prevent someone from coming to take medications from the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:45 p.m., with RN 1, RN 1 stated, medication cart being locked is for safety and if left unattended or not locked there is a risk that other resident or staff could take medications from the medication cart and a potential for harm and medication error if a confused resident was to take medication from the unlocked medication cart. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated [DATE], indicated Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 2. During a review of Resident 390's Admission Record, the Admission Record indicated Resident 390 was admitted to the facility on [DATE] with a diagnoses included Alzheimer's disease (a progressive brain disorder that gradually destroys memory, thinking skills, and the ability to perform daily tasks) and COVID-19 (a respiratory disease caused by coronavirus) During a review of Resident 390's, History and Physical (H&P) dated [DATE], the H&P indicated Resident 390 does not have the capacity to understand and make decisions. During a concurrent observation and interview on [DATE] at 10:22 p.m., with LVN 4 on Station Subacute Med Cart Red Zone, LVN 4 opened the Med Cart Red Zone and observed inside the locked drawer was a bag with bottles of medications labeled for Resident 390. LVN 4 stated the bag of medications belong to Resident 390 and were brought from resident's home and the facility was not using the resident's home medications. The medications included: Lorazepam 0.5 milligrams (mg - unit of measure of weight) Linzess (used to treat irritable bowel syndrome with constipation) 72 micrograms (mcg - unit of measure of weight) Memantine (used to treat memory loss) 5 mg Levothyroxine (used to treat low thyroid) 25 mcg Meclizine (used to treat motion sickness like nausea, vomiting or dizziness) 25 mg PreserVision AREDS 2 (supplement), the medication bottle did not include a label or include Resident 390's name on the bottle or instructions for use. During an interview on [DATE] at 10:50 a.m., with LVN 4, LVN 4 stated she was not aware that a controlled medication, lorazepam was stored inside the bag of home medications for Resident 390. LVN 4 opened the lorazepam bottle inside was four tablets, two were lorazepam and LVN 4 could not tell what medication the other two tablets were. LVN 4 stated Resident 390's home medication, lorazepam should have been accounted for, removed from the medication cart, and given to the Director of Nursing (DON) or returned to the resident's family. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 11:02 a.m., with Registered Nurse (RN) 2 and LVN 4, Resident 390 physician Order Summary Report was reviewed. RN 2 stated there was no physician order of Lorazepam for Resident 390. RN 2 stated the Lorazepam should have been removed from the medication cart and taken to the DON. RN 2 stated medication error or loss of medication could happen, when Resident 390's medications brought from home and no physician order were stored in the medication cart available for use. During a review of the facility's P&P titled, Medications Brought to the Facility by a Resident or Family Member, dated ,d+[DATE], indicated Unauthorized medications are not accepted by the facility .Medications not ordered by the resident's physician or unacceptable for other reasons, are returned to the family or designated agent. If unclaimed within (thirty) days, the medications are disposed of in accordance with facility medication destruction/disposal procedures .Medication storage conditions are monitored on a monthly basis by the consultant pharmacist and corrective actions taken if problems are identified. 50144 3. During a review of Resident 28's Admission Record, the Admission Record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following unspecified cerebrovascular disease (condition that affect the blood vessels in the brain and spinal cord) affecting left non-dominant side and unspecified asthma (chronic lung disease). During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognition was not intact, and was dependent for eating, hygiene, and bathing. During a review of Resident 28's Physician Order Summary, the Physician Order Summary indicated an order for Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) milligrams (mg- a unit of measurement) /3 milliliters (ml - a unit of measurement), 3 ml inhale orally every 6 hours as needed for wheezing (a high-pitched, whistling sound that occurs when air moves through narrowed airways in the lungs) ordered on [DATE]. During a concurrent observation and interview on [DATE] at 1:05 p.m. with Licensed Vocational Nurse (LVN) 10, Station 4 medication cart was inspected. There was an opened foil pack of Ipratropium-Albuterol Inhalation Solution with no open date. LVN 10 stated the open date should have been written on the foil pack because the medication must be used within 2 weeks after foil envelope was opened per the manufacturer guidelines. LVN 10 stated if there was no open date, the licensed nurse will not know when the medication expires. LVN 10 stated if Resident 28 received expired Ipratropium-Albuterol, there is a risk that the medication's potency (quantity of drug necessary to produce a given effect) will be compromised, and resident will continue to have shortness of breath , SOB, wheezing or other breathing problems. During a review of the facility's policy and procedure (P&P), titled Medication Storage in the Facility: Storage of Medications, dated Date [DATE], The P&P indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 Based on interview and record review, the facility failed to honor food request and food preferences of one of two sampled residents (Resident 76) by ensuring requested food is provided and accommodated. This failure had the potential to place Resident 76 at risk of not having her nutritional needs met. Findings: During a review of Resident 76's Admission Record, the Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), pulmonary hypertension(a condition where the blood pressure in the lungs is higher than normal). During a review of Resident 76's Minimum Data Set (MDS- a resident assessment tool) dated 11/20/2024, the MDS indicated the resident had an intact cognition (thought process) and was dependent (helper does all the effort) on staff with toileting hygiene, bathing, lower body dressing (the ability to dress and undress below the waist),and transfer to and from a bed to a chair or wheelchair. During a review of Resident 76's Order Summary Report dated 11/18/2024, the Order Summary Report indicated an order of No added salt/Controlled carbohydrate diet (CCHO-diet focuses on limiting consumption of foods high in carbohydrates). During a review of Resident 76's Nutrition Dietary Review dated 3/16/2020, the Nutrition Dietary Review indicated the resident liked brown rice, wheat bread and was on CCHO diet. During an interview on 2/12/2025, at 3:48 p.m., and subsequent interview on 2/14/2025, at 9:30 a.m. with Resident 76, Resident 76 stated the kitchen always run out of gravy , chicken noodle soup , bacon or cream of wheat. Resident 76 stated the unit with even numbers always get their trays last among the residents and always run of food and given alternative food instead. Resident 76 stated she would get white bread and white cheese bread at times or white cheese and the kitchen was aware of her food preferences because it was on her meal ticket. During an interview on 2/14/2025, at 9:58 a.m. with Certified Nursing Assistant (CNA 11), CNA11 stated Resident 76 requested 3 cups of cream of wheat but the kitchen ran out yesterday (2/13/2025) and offered the resident oatmeal. CNA11 stated the resident did not get her cream of wheat yesterday and sometimes the kitchen ran out of food items that are popular among the residents like bacon or soup. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/15/2025, at 7:54 a.m. with Dietary Aide (DA 2) , DA 2 stated sometimes the kitchen did not have enough bacon or soup depends on what they have prepared for that meal. DA 2 stated residents would get upset and could affect their appetite if they do not receive what they request for a particular meal. DA 2 stated the residents should get what they want and request. During an interview on 2/15/2025, at 8:12 a.m. with Assistant Cook, Assistant [NAME] stated if the resident requested for a particular food item and the food was no longer available in the kitchen, the [NAME] could cook some more to accommodate the resident's request even the kitchen had finished preparing and cooking the food for the residents. Assistant [NAME] stated Resident 76 liked raisin toast and bacon. Assistant [NAME] stated that it's true that sometimes the kitchen ran out of cooked food items like potato, bacon, rice because residents requested more of those food items frequently. Assistant [NAME] stated the kitchen should make more food like bacon, cream of wheat and the residents should get their food the way they like it because they could get sick and lose weight. During an interview on 2/14/2025, at 4:53 p.m. with Dietary Supervisor (DS), DS stated he does see the residents unless there is a complaint and did not know when was the last time, he saw Resident 76 to see if there is any concern about her food.DS stated it was a miscommunication either from nursing or kitchen staff when Resident 76 did not get what she wanted like bacon or cream of wheat. During a review of facility's policy and procedure(P&P) titled Food Preferences revised 7/2017, the P& P indicated individual food preferences will be assessed and when possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. The P& P indicated the nursing staff will document resident's food and eating preferences in the care plan and the resident had the right not to comply with therapeutic diets.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49889 Based on observation, interview and record review, the facility failed to: a. Ensure Lysol bleach cleaner was not stored in the dry food storage area. b. Ensure the drain to the ice machine was free from dirt and debris. c. Ensure prepared food items in the refrigerator had the prepare date and the use by date. d. Ensure the freezer temperature logs were completed daily. These failures have the potential to expose residents to food-borne illnesses (any illness resulting from ingestion of food contaminated with bacteria, viruses, or parasites) and put residents at risk for cross contamination (unintentional transfer of harmful bacteria from one object to another). Findings: During a concurrent observation and interview on 2/11/2025, at 8:27 a.m. with the Assistant [NAME] in the dry food storage area, a bottle of Lysol bleach cleaner was observed hanging off of a shelf. The Assistant [NAME] stated Lysol bleach cleaner should not be stored in the dry food storage there could be a chemical spill and leak into the product and could potentially be fatal. During a concurrent observation and interview on 2/11/2025 at 8:35 a.m. with the Dietary Aide 1 (DA) in the kitchen, DA1 stated that the temperature for the freezer needs to be checked each shift and documented, and the freezer temperature log was missing temperatures. DA1 stated we need to make sure the foods temperature is checked to preserve the freshness and food can spoil if not kept at the correct temperatures, bacteria can grow, and the residents that would eat it could get sick. During a concurrent observation and interview on 2/11/2025, at 8:42 a.m. with DA 2 in the kitchen. The DA 2 stated the tray of sandwiches and tray of puddings in the refrigerator did not have dates as to when they were prepared or when they should no longer be served to the residents. DA 2 stated residents could get sick if food is served out of date. During a concurrent observation and interview on 2/14/2025, at 4:39 p.m. with Dietary Supervisor in the kitchen. The DS stated the ice machine drain did have dirt and debris around it, and there is a possibility for bacteria to grow when not kept clean. The DS stated that Lysol bleach cleaner should not have been left in the dry food storage area. DS stated that it is a chemical hazard if a resident ingested it and it is poisonous. The DS stated everything needs to be labeled and dated before it goes in the refrigerator, we need to ensure the food is not out of date and can be served safely. DS stated there is a potential for gastro intestinal (GI-relating to the stomach and the intestines) issues if food is served out of date. DS stated freezer temperature's need to be checked and documented every shift to ensure food is kept at a temperature below zero, there is a potential for GI issues if food is not stored at the right temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 2/15/2025, at 7:31 a.m. with the Administrator (ADM), the ADM stated chemicals should not be left in food storage areas, there is a potential for an adverse reaction. The ADM stated the ice machine drain should not have dirt or debris, there should be proper sanitation done for infection control. The ADM stated food needs to be properly label with open dates and use by dates, staff would not know when the food is out of date and there could be a possible adverse reaction for the residents if served out of date food. The ADM stated food can spoil when not kept at the proper temperature that's why temperature logs need to be kept up to date. During a review of the facility's policy and procedure (P&P) titled Food Receiving and Storage, dated 10/2017, the P&P indicated foods shall be received and stored in a manner that complies with safe food handling. All food stored in the refrigerator or freezer will be covered labeled and dated (use-by date). Soaps, detergents, cleaning compounds or similar substances will be stored in separate storage areas from food storage and labeled clearly. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition service manager or designee and documented according to state-specific requirements. During a review of the facility's policy and procedure (P&P) titled Sanitization, dated 10/2017, the P&P indicated the food service area shall be maintained in a clean and sanitary manner. All kitchen, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Ice machines and ice storage containers will be drained, cleaned and sanitized per manufactures instructions and facility policy.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49862 Based on interview and record review, the facility's Quality Assessment and Assurance (QAA) and Quality Assurance Performance Improvement (QAPI) committee failed to establish a system for: 1. Medication Management and safety by reducing medication errors and ensure accurate medication administration to enhance resident safety. 2. Falls and fall -related injuries by minimizing the occurrence of falls among residents and reduce the severity of fall-related injuries. 3. Pressure ulcers monitoring for residents who are at risk for developing or acquiring pressure ulcers. These deficient practices resulted for residents not receiving medically related necessary care, resulting in medication errors, injury related to falls, lack of monitoring and document pressures injuries. Findings: During an interview on 02/15/2025 at 7:51 p.m. with the Administrator (ADM), the ADM stated all what they are working, but cannot proved how to prevent highest medication errors rate, how to present fall and injury, and how to over and present pressure injury. There were no safety measures in place to prevent other residents' meds errors and monitory. During a review of the facility's policy and procedure (P/P) titled, Quality Assurance and Performance Improvement (QAPI) Plan, revised 01/2025, indicated the facility to establish and maintain an ongoing, systematic and proactive facility-wide process and data driven information to plan to measure and assess as well as to carry out the plan and improve resident care, outcomes and safety based on its mission, strategic goals and objectives.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45269 49145 49862 Based on observation, interview, and record review, the facility failed to observe infection control practices by failing to: 1.Ensure oxygen tubing and bags were changed and labeled weekly for Residents 126 and 500. 2.Ensure tube feeding and water bags were changed and labeled for Resident 218. 3.Ensure the licensed nurse removed her personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments.) when exiting Resident 517's room and prior to walking out into the hallway. 4.Ensure the Certified Nursing Assistant (CNA) will call housekeeping to properly clean the floor in Resident 106's room after feces are found scattered in the floor. 5.Ensure a visitor was educated and informed about the use of PPE) was worn when entering Resident 169's room who had Candida Auris(C. Auris- a yeast that can cause severe infections, including bloodstream infections and often resistant to antifungal medications , difficult to treat and spreads easily through contaminated surfaces or medical equipment) and on Contact Isolation(steps that facility's visitors and staff follow to help stop spreading germs that can be spread by touching the resident or surfaces in the room). These failures had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for the spread of infection. Findings: During a review of Resident 126's Admission Record, the Admission Record indicated Resident 126 was admitted to the facility on [DATE], readmitted on [DATE] with diagnoses including myocardial infarction ({MI}- heart attack) and chronic obstructive pulmonary disease ({COPD}- a chronic lung disease causing a difficulty in breathing). During a review of Resident 126's Minimum Data Set ({MDS}- a resident assessment tool) dated 11/25/2024, the MDS indicated Resident 126's cognition (ability to think, understand, learn, and remember) is intact. The MDS indicated Resident 126 required substantial/maximal assistance (helper does more than half the effort) with toileting, showering/bathing, and dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 500's Admission Record, the Admission Record indicated Resident 500 was admitted to the facility on [DATE] with diagnoses including congestive heart failure ({CHF}- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and atrial fibrillation (an irregular and often very rapid heart rhythm). During a review of Resident 500's MDS dated [DATE], the MDS indicated Resident 500's cognition is intact. The MDS indicated Resident 500 required substantial/maximal assistance with toileting, showering/bathing, and dressing. During a review of Resident 218's Admission Record, the Admission Record indicated Resident 218 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (blood flow to the brain is blocked) and dysphagia (difficulty swallowing). During a review of Resident 218's MDS dated [DATE], the MDS indicated Resident 218's cognition was moderately impaired. The MDS indicated Resident 218 was dependent (helper does all the effort) with personal hygiene, toileting, showering/bathing, and dressing. During a review of Resident 517's Admission Record, the Admission Record indicated Resident 517 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus ({DM}- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension ({HTN}- high blood pressure). During a review of Resident 517's MDS dated [DATE], the MDS indicated Resident 218's cognition is intact. During a review of 517's Change in Condition (COC) dated 2/10/2025, the COC indicated Resident 517 tested positive for Covid (a highly contagious respiratory disease). During a concurrent observation and interview on 2/11/2025 at 11:08 a.m., with Licensed Vocational Nurse (LVN) 8, LVN 8, confirmed Resident 126 and 500's oxygen tubing and bag were not dated so she is not sure if or when they were changed. LVN 8 stated the oxygen tubing and bag is supposed to be changed once a week and labeled with the residents name and the date for infection control purposes to ensure bacteria does not grow in the tubing which could potentially cause a respiratory infection, pneumonia, or irritation around the nasal area. During a continued concurrent observation and interview on 2/11/2025 at 11:19 a.m. with LVN 8, LVN 8 stated Resident 218's tube feeding, and water bag was not labeled or dated. LVN 8 stated the tube feeding and water bags are supposed to be changed every 24 hours. LVN 8 stated its important to change and date every 24 hours for infection control because if not it can potentially cause stomach issues if the feeding spoils from not being changed. During a concurrent observation and interview on 2/11/2025 at 3:09 p.m. with the Registered Nurse (RN) 3, RN 3 was observed coming out of Resident 517's room into the hallway still wearing her PPE. RN 3 stated she made a mistake and should have removed her PPE prior to exiting the resident's room because the PPE is contaminated, and it could potentially contaminate others and spread the infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/15/2025 at 4:54 p.m. with the Director of Quality Assurance (QA), the QA stated its important to change and label oxygen tubing and tube feeding bags to prevent the spread of infection. Stated if the tubing's are not changed when they are supposed to be changed, it can potentially place the residents at risk for infection. The QA stated PPE should be removed before leaving a residents room because if they do not, it can lead to a break in infection control placing the residents and staff at risk for infection. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, Delivery Device, dated 1/2025, the P&P indicated, Plastic bags are replaced weekly and as needed. Label the delivery device tubing at the point that it attaches to the humidifier or nipple adapter with the date. Delivery devices are to be changed/replaced according to specific policy. During a review of the facility's P&P titled, Enteral Feedings- Safety Precautions, dated 12/2018, the P&P indicated, Change administration sets for open-system enteral feedings and water flush bag sets at least every 24 hours. During a review of the facility's P&P titled, Standard Precautions, dated 2/2025, the P&P indicated, Before leaving the resident's room or cubicle, remove and discard PPE. 4.During a review of Resident 106's Admission Record, the Admission Record indicated was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included dementia(a progressive state of decline in mental abilities), unspecified psychosis(a severe mental condition in which thought, and emotions are so affected that contact is lost with realty), and heart failure(condition where the heart muscle becomes weakened or stiff making it difficult to pump blood effectively). During a review of Resident 106's History and Physical (H&P) dated 1/7/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment(a serious decline in mental function that makes it hard to think, learn, and function independently)and was dependent on staff with bathing/showering. The MDS indicated the resident required supervision or touching assistance with dressing and toileting hygiene. During a concurrent observation and interview on 2/12/2025, at 10:18 a.m. in Resident 106's room and subsequent interview on 2/14/2025, at 9:07 a.m. with Certified Nursing Assistant (CNA 4), CNA 4 was providing care for Resident 106. Observed small areas of feces were scattered in the floor. CNA 4 stated Resident 106 had a bowel movement and some of the feces had probably fallen off the floor when the resident came from the shower room. Observed CNA4 wiped off the floor with dry towels where areas of feces are found. CNA4 stated she would come back to the room to disinfect and make Resident 106's bed. Observed CNA 4 walked out of the room and carried some clean linens back to the resident's room. She stated she forgot to call the housekeeping because her mind was blank at that time. CNA 4 stated she should have put a sign and call housekeeping to properly clean the dirty floor to prevent spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/2025, at 10:23 a.m. with Licensed Vocational Nurse (LVN 14), LVN 14 stated the staff should wipe off the feces with dry towel, call housekeeping right away , and place a sign to ensure people would not be stepping on the dirty floor to prevent contamination and spread of infection. During an interview on 2/15/2025, at 7:24 p.m. with Chief Clinical Officer (CCO), CCO stated feces on the floor should be cleaned immediately, put the precaution cone and call housekeeping to clean and disinfect the floor to prevent break in infection control and spread of infection. 5. During a review of Resident 169's Admission Record, the Admission Record indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses that included unspecified candidiasis(infection caused by an overgrowth of a type of yeast in the body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and pressure induced deep tissue damage of sacral region(prolonged pressure applied to the lower back that caused damage to the underlying soft tissues, muscles, fat due to restricted blood flow). During a review of Resident 169's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognitive skills and required partial/ moderate assistance with bed mobility. The MDS indicated the resident required substantial/ maximal assistance with toileting hygiene, bathing, and dressing. During a review of Resident 169's Order Summary Report dated 11/30/2024, the Order Summary Report indicated an order for Contact Isolation for Candida Auris. During a review of Resident 169's Care Plan initiated on 9/24/2024, the Care Plan indicated Resident 169 had a multi-drug-resistant organism(microorganisms, predominantly bacteria that are resistant to a lot of antibiotics or antifungals) called C. Auris. The Care plan goal indicated the resident will respond to treatment through the review date. The Care Plan interventions included instructing visitors / family/caregivers to wear disposable gown and gloves when in resident's room and to wash hands before leaving room. During a review of Resident 169's Candida Auris Surveillance NAA W reflex fungal culture (test to detect presence of Candida Auris) dated 9/17/2024, the Candida Auris Surveillance indicated C. Auris was detected. During an observation on 2/14/2025, at 2:58 p.m. in Resident 169's room, a signage for Contact Isolation was posted and an isolation cart (medical cart that holds PPE and supplies for patients with infectious diseases)was visible near the entryway of the door. Observed a visitor wearing a surgical mask and not wearing a PPE was sitting next to the resident's bed. During a concurrent observation and interview on 2/14/2025, at 3:01 p.m. with LVN 12, LVN 12 stated the visitor inside Resident 169's room was a family member (FM) and should be wearing a PPE when visiting. LVN 12 stated the resident was in contact isolation because of C. Auris. LVN 12 stated the visitor might have forgotten to wear PPE and will inform her on what precautions to observe when visiting the resident. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Nursing Center	22617 So. Vermont Ave Torrance, CA 90502

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/15/2025, at 1:54 p.m. with CNA 5, CNA5 stated Resident 169 is on contact isolation and everything the resident had touched could carry the germs. CNA5 stated she performed hand hygiene, wear gown, gloves, mask and practice hand hygiene before and after entering the room. CNA5 stated infection could be spread to other residents, staff and visitors if contact isolation is not observed when entering Resident 169's room. During an interview on 2/14/2025, at 4:38 p.m. and subsequent interview on 2/15/2025, at 5:10 p.m. with Director of Quality Assurance (DQA), DQA stated contact isolation should be observed in resident who had C. Auris. DQA stated the visitor should have worn gown, gloves, mask and practiced hand hygiene before and after visiting. DQA stated the staff is responsible in providing education to visitors about isolation precautions and infection control prevention. DQA stated a break in infection control could occur and could place residents, visitors and staff at risk for infection if contact isolation is not observed. During an interview on 2/5/2025, at 7:24 p.m. with Director of Nursing (DON), DON stated the licensed nurses should provide education about contact isolation for C. Auris to the visitors for everyone's protection and prevention of spread of infection to the staff, visitors and other residents. During a review of facility's P&P titled Candida Auris updated 9/11/2024, the P&P indicated C. Auris spreads easily and can cause life-threatening infections in some patients. The P&P indicated patients who are colonized (person has the yeast in their body but not sick) can spread C. Auris the same ways that patients who are infected can and patients can remain colonized for several weeks, months or longer even if they never had symptoms. During a review of facility's P&P titled Transmission Based Precautions revised 6/2024, the P&P indicated contact precautions are used for residents with known or suspected infections that represent an increased risk for contact transmission. The P&P indicated using PPE, including gloves and gowns and should be used for all interactions that may involve contact with the resident or the resident's environment.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on interview and record review, the facility failed to implement the antibiotic stewardship program policy when the antibiotic (a substance used to kill bacteria and to treat infections) did not meet Loeb's or McGeer's Criteria (criteria used to determine appropriate use of antibiotics) for two of three sampled residents (Resident 98) receiving ampicillin (antibiotic used to treat bacterial infections). This deficient practice had the potential to increase antibiotic resistance and provide antibiotics without justification. Findings: During a review of Resident 98's Admission Record, the Admission record indicated Resident 98 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following unspecified cerebrovascular infarction (CVA-stroke, loss of blood flow to a part of the brain) affecting left non-dominant side and neuromuscular dysfunction of bladder (condition where the nerves controlling bladder function are damaged, leading to impaired bladder muscle coordination resulting in difficulty urinating or incontinence). During a review of Resident 98's Minimum Data Set (MDS-a resident assessment tool) dated 11/18/2024, the MDS indicated Resident 98's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired, required supervision for eating and oral hygiene, required maximal assistance (helper does more than half the effort) for dressing and showering, and was dependent (required complete assistance of 2 or more helpers) for toileting. During a review of Resident 98's physician order summary printed on 2/15/2025, the order indicated Ampicillin Sodium Injection Solution Reconstituted 1 Gram (GM - a unit of measurement) Use 1 gram intravenously every 6 hours for urinary tract infection (UTI- an infection in the bladder/urinary tract) for 5 days. During a concurrent interview and record review on 2/14/20 at 2:50 p.m. with the Director of Quality Assurance (QA), Resident 98's Infection Screening Evaluation, dated 1/31/2025). Resident 98's Infection Screening Evaluation indicated, No IPC Case Triggered. The QA stated Resident 98's symptoms did not meet criteria, and there is no documentation indicating the physician was notified. The QA stated the physician should be notified if a resident does not meet Loeb's or Mcgeer's criteria to see if medication needs to be reevaluated. During an interview on 2/15/2025 at 7:24 p.m. with the Chief Clinical Officer (CCO), the CCO stated if the resident does not meet Mcgeer's criteria, there can be a negative outcome for the resident. The CCO stated the resident can be at risk for multidrug resistant organisms or antibiotics unnecessarily or without justification. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Infection and Control Program dated October August 2023, P&P indicated, the antibiotic usage is evaluated and practitioners are provided feedback on review.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview and record review, the facility failed to offer, educate, and track influenza vaccinations for residents per facility's policy for one or five sampled residents (Resident 218). This failure had the potential to place all residents at risk for infection of influenza. Findings: During a review of Resident 218's Admission record , the Admission Record indicated Resident 218 was admitted to the facility on [DATE] with a diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following unspecified cerebrovascular infarction (CVA-stroke, loss of blood flow to a part of the brain) affecting left non-dominant side. During a review of Resident 218's Minimum Data Set (MDS - a resident assessment tool), dated 12/20/2024, the MDS indicated Resident 218's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired and was dependent for hygiene, bathing, and dressing. During a concurrent interview and record review on 2/14/20 at 2:18 p.m. with the Director of Quality Assurance (QA), Resident 218's Immunization History Reports. The QA stated Resident 218 was eligible for the 2024-2025 influenza vaccine, and did not have documentation indicating that the 2024-2025 influenza vaccine was offered, education was provided, or that Resident 218 declined the vaccine. The QA stated it is important to offer all vaccinations to all eligible residents to prevent the spread of infection. During an interview on 2/15/2025 at 7:24 p.m. with the Chief Clinical Officer (CCO), the CCO stated it is important for residents to be offered the influenza vaccine to protect residents, lessen the severity of illness, and prevent potential outbreaks. During a review of the facility's policy and procedure (P&P), titled Influenza Vaccine, revised October 2019, the P&P indicated: a. All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associate with vaccinations against influenza. b. Prior to the vaccination the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. c. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the residence medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50144 Based on observation, interview and record review, the facility failed to offer, educate, and track coronavirus vaccinations for residents per facility's policy for two or five sampled residents (Resident 218 and Resident 121). This failure had the potential to place all residents at risk for infection of coronavirus. Findings: A. During a review of Resident 218's Admission record, the Admission record indicated Resident 218 was admitted to the facility on [DATE] with a diagnosis including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or paralysis on one side of the body) following unspecified cerebrovascular infarction (CVA-stroke, loss of blood flow to a part of the brain) affecting left non-dominant side. During a review of Resident 218's Minimum Data Set (MDS - a resident assessment tool), dated 12/20/2024, the MDS indicated Resident 218's cognition (ability to learn, reason, remember, understand, and make decisions) was moderately impaired and was dependent for hygiene, bathing, and dressing. B. During a review of Resident 121's Admission record, the Admission record indicated Resident 121 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure and dependence on respirator (ventilator- a medical device to help support or replace breathing). During a review of Resident 121's MDS, dated [DATE], the MDS indicated Resident 121's cognition was severely and was dependent for hygiene, bathing, and dressing. During a concurrent interview and record review on 2/14/20 at 2:18 p.m. with the Director of Quality Assurance (QA), Resident 218 and Resident 121's Immunization History Reports: A. The QA stated Resident 218 was eligible for the 2024-2025 coronavirus vaccine, and did not have documentation indicating that the 2024-2025 coronavirus vaccine was offered, education was provided, or that Resident 218 declined the vaccine. B. The QA stated Resident 121 was eligible for the 2024-2025 coronavirus vaccine, and did not have documentation indicating that the 2024-2025 coronavirus vaccine was offered, education was provided, or that Resident 121 declined the vaccine. The QA stated it is important to offer all vaccinations to all eligible residents to prevent the spread of infection. During an interview on 2/15/2025 at 7:24 p.m. with the Chief Clinical Officer (CCO), the CCO stated it is important for residents to be offered the coronavirus vaccine to protect residents, lessen the severity of illness, and prevent potential outbreaks. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Covid-19 Policy, revised October 2024, the P&P indicated it is the policy of this facility to maintain a safe environment by encouraging and supporting COVID19 vaccination for eligible residents and healthcare personnel. During a review of the facility's policy and procedure (P&P), titled Vaccination of Residents, revised October 2019, the P&P indicated: a.All residents will be offered vaccines that aid in preventing infectious disease unless the vaccine is medically contraindicated of the resident has already been vaccinate. b.Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. c.Provision of such education shall be documented in the resident's medical record. d.If vaccines are refused, the refusal shall be documented in the resident's medical record.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 49862 Based on observation, interview, and record review, the facility failed to accommodate no more than four residents, by failing to ensure rooms provide at least 80 square feet ([sq. ft.] unit of measurement) per resident in multiple resident bedrooms. The insufficient space could lead to inadequate nursing care to the residents. This failure had the potential to decrease the resident's privacy, quality of care and quality of life. Findings: During a review of the facility's Client Accommodations Analysis Form (CAAF) completed by the facility on 02/15/25, the facility had 83 rooms that measured less than 80 sq. ft. per resident in multi-bedrooms. The CAAF indicated rooms: 105, 107, 109 , 111,113,115,117,119,121,123,125,127,201,202, 203,205,206, 207, 208, 209, 210,211,212, 214,216,218, 220, 301,302,303,304,305,306,307,308,309,310,311, 312,401,402,403,404,405,407,408,409, 410,411,412,413,414,415,416,417,418, 419,421,501,502,503,504,505,506,507,508,509,510,511,512,513, 514,515,516,517,518,519, 520, 521, 522, 523, 525, and 527 are less than 80 square feet to accommodate residents in each room. During an observation made to the requested rooms during the annual recertification survey at the facility from 02/11/2025 to 02/15/25 indicated no concerns or problems with privacy, safety, and residents' care. During an interview on 02/15/25 at 3:42 p.m. with the Administrator (ADM), ADM stated residents' care was not affected and no one was complaining that their room is crowded or affected their mobility and safety. The ADM stated the facility will be requesting a room waiver.