STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555071	A. Building B. Wing	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyview Care Center	2000 W Washington Bl Los Angeles, CA 90018

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on interview and record review, the facility failed to implement 1 of 3 sampled residents ' , (Resident 1) care plan titled, Resident non-compliant manifested by refusing medications, history of refusing to take medications for 2 months, which indicated to hold an Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) to address non-compliant behavior. This failure resulted in Resident 1 ' s continued refusal of medications not addressed, and had the potential to affect in maintaining the resident ' s highest practicable physical, mental and psychosocial well-being. Findings: During a review of Resident 1 ' s Admission Record, dated 2/3/2025, the Admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnosis of schizophrenia (a chronic mental health condition characterized by profound disruptions in thought processes, perceptions, emotions, and behaviors), suicidal ideations (occurs when you think about or consider death or suicide), and restlessness and agitation. During a review of Resident 1 ' s Order Summary Report dated 12/1/2024, the order summary report indicated a physician order, dated 11/16/2024 for Lithium Carbonate Oral Capsule 300 milligrams (mg.- a unit of measurement), one (1) capsule by mouth three times a day for paranoid schizophrenia. During a review of a Resident 1 ' s care plan titled Resident non-compliant manifested by refusing medications, history of refusing to take medications for 2 months; at risk for not being treated related to refusing medication, dated 11/19/2024, the interventions indicated an IDT should be held as needed to address non-compliant behavior, document Resident 1 ' s response to specific non-compliance as needed, notify any risks/ consequences as a result of non-compliance, involve resident/ significant others in care to gain cooperation. During a review of Resident 1 ' s Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/22/2024, the MDS indicated Resident 1 had clear speech and had the ability to express ideas and wants and understands. The MDS indicated Resident 1 was independent with daily task of eating, toileting hygiene, and personal hygiene. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s January 2025 Medication Administration Record (MAR), the MAR indicated Resident 1 had refused Lithium Carbonate Oral Capsule 300 mg on 1/13/2025 at 1 p.m. and on 1/19/2025 at 9 a.m. and 1 p.m. During a review of Resident 1 ' s progress notes dated 1/13/2025 at 12: 25 p.m., the progress notes indicated on 1/13/2025 during the morning shift (time not specified), Resident 1 had episodes of distress, anger, verbalization of the F . word, threatening nurses, and was unable to control her thinking. The progress notes indicated Resident 1 refused some of the morning medications and had refused noon medications. The progress notes did not indicate physician was notified of Resident 1 ' s refusal. During a review of Resident 1 ' s progress notes dated 1/13/2025 at 9:42 p.m., the progress notes indicated Registered Nurse (RN) had documented Resident 1 was yelling the F . word after being informed she will be transferred to a general acute care hospital (GACH). The progress notes indicated Resident 1 yelled and stated she was not going to a psyche hospital. The progress notes indicated Resident 1 started to pace around the facility and yelled the F . word when asked to go back to her room. The progress notes indicated Resident 1 stated, she will not follow anything the RN said and will not take any psyche medications. During a review of Resident 1 ' s progress notes dated 1/19/2025, the progress notes did not indicate the physician was notified on 1/19/2025 at 9 a.m. and 1 p.m. when Resident 1 refused the Lithium Carbonate. During a telephone interview on 2/4/2025 at 3:44 p.m. with the Director of Nursing (DON), the DON stated since Resident 1 was admitted with a diagnosis of non-compliance, an IDT meeting should have been conducted to discuss Resident 1 ' s refusal of medications. During a review of the facility ' s policy and procedure (P&P) titled, Requesting, Refusing and/or Discontinuing Care or Treatment, dated 2/2021, the P&P indicated if a resident refuse care or treatment, an appropriate member of IDT should meet with the resident/resident representative to determine why he or she is refusing, try to address his or her concerns and discuss alternative options and discuss the potential outcomes or consequences (positive and negative) of the decision.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 36331 Based on observation, interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Work Practices, which indicated drinks should not be stored in areas of possible contamination. This failure had the potential to cause cross contamination. wellness. Findings: During an observation on 2/3/2025 at 11:15 a.m., the Licensed Vocational Nurse (LVN 1) was observed reviewing the computer screen on the medication (med) cart and was drinking cranberry juice. During a concurrent observation and interview on 2/3/2025 at 11:35 a.m., LVN 1 was observed again with a cup of cranberry juice and her personal cell phone was ringing on top of the med cart. LVN 1 stated the juice and cell phone belonged to her. LVN 1 stated she knew she should not be drinking cranberry juice and should not place her personal cell phone on top of the med cart because germs may spread, and she could get sick. During a review of the facility's P&P titled, Work Practices, dated 4/2023, the P&P indicated food, and drink shall not be stored in areas with possible contamination.