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	04/25/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Implement its policy and procedure (P&P) titled, Identifying Abuse which indicated the facility did not condone any form of resident abuse or neglect for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 2 physically assaulting Resident 1, causing serious injuries such as a swelling to the right side of Resident 1's forehead, and a zygomatic arch fracture (a break in the cheekbone). Findings: a. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hypertension (high blood pressure), bilateral hearing loss (hearing loss in both ears), type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypercalcemia (a condition in which the calcium level in the blood becomes too high). During a review of Resident 1's Minimum Date Set (MDS- a resident assessment tool), the MDS indicated Resident 1's cognitive (thinking) skills for daily decision making were intact. The MDS indicated Resident 1 required setup and clean up assistance with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 1's Change of Condition (COC- a communication tool used to communicate a resident's change of condition), dated 4/19/2025, the COC indicated on 4/19/2025, a staff member reported hearing a loud noise coming from the hallway. The COC indicated the staff member went to investigate the noise and saw Resident 1 lying on the floor. The COC stated the staff member saw Resident 2 physically assaulting Resident 1 with his hands and feet. (continued on next page)

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

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's General Acute Care Hospital (GACH) records, dated 4/19/2025, the GACH records indicated Resident 1 was diagnosed with a traumatic injury to the right ear and temple area (side of the head behind the eyes, located between the forehead and ear), temporary unconsciousness (the state of not being awake) possibly due to head trauma, a suspected zygomatic arch fracture (break in the cheekbone), and hearing loss in the right ear. The GACH records indicated Resident 1 was ordered Hydrocodone-Acetaminophen (Norco, used to treat moderate to severe pain) 5/325 milligrams (mg, unit of measurement) 1 tablet by mouth every 4 hours for pain. The GACH records indicated Resident 1 was admitted to the GACH on 4/19/2025 and discharged on 4/24/2025. During a review of Resident 1's facility readmission Progress Note dated 4/24/2025 at 4:40 p.m., the progress note indicated Resident 1 was readmitted to the facility from the GACH where he was treated for status post (s/p) right temple and ear subarachnoid (the space between the brain and the thin tissues covering it) and subdural (collection of blood in the brain) hemorrhages (bleeding from a broken vessel either inside or outside of the body). b. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included paranoid schizophrenia (a mental health condition characterized by delusions that others are persecuting, tracking, or otherwise monitoring a person), mood affective disorder (a mental health condition that primarily affects your emotional state), hypertension, and type 2 diabetes. During a review of Resident 2's MDS, the MDS indicated Resident 2's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 2 was independent with ADLs. During a review of Resident 2's care plan titled, Resident non-compliance manifested by: Resident at risk for not being treated related to refusing medication, dated 3/23/2025, the care plan indicated Resident 1 will comply with the facility's policy/protocols, physician orders daily. The interventions indicated an interdisciplinary team (IDT, group of different disciplines working together towards a common goal of a resident) meeting to be held address non-compliant behavior. During a review of Resident 2's physician's order, dated 4/3/2025, the physician's order indicated Haldol (a typical antipsychotic [medication used to treat mental disorders] medication used to treat certain types of mental disorders) 10 mg intramuscularly (an injection administered into a muscle) twice a day starting 4/3/2025. During a review of Resident 2's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of April 2025, the MAR indicated Resident 2 refused Haldol daily from 4/3/2025 to 4/19/2025. During a review of Resident 2's Psychiatric Initial Evaluation dated 4/50/2025, the evaluation indicated Resident 2 appeared visibly anxious, suspicious, and mildly disoriented. The evaluation indicated over the past month the resident had exhibited increasing paranoia (unjustified suspicion and mistrust of other people or their actions) and was now expressing fixed delusions (having false or unrealistic beliefs) that others were attempting to harm him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/25/2025 at 10:01 a.m., with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated on 4/19/2025 around 8:30 a.m., she heard loud noises coming from the patio hallway. CNA 1 stated she ran over and saw Resident 2 standing over Resident 1, kicking and stomping (to put a foot down on the ground hard and quickly, making a loud noise, often to show anger) on Resident 1's head. CNA 1 stated Resident 1 was on the floor and appeared unconscious. CNA 1 stated staff immediately separated the residents. During an interview, on 4/25/2025 at 10:58 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated he heard a bunch of commotion at the patio hallway. LVN 1 stated he saw CNA 1 run to the patio hallway and began screaming. LVN 1 stated he ran over and saw Resident 1 on the floor. LVN 2 stated Resident 2 was kicking and stomping on Resident 1's head. LVN 1 stated Resident 1 was unconscious for 2 minutes. LVN 1 stated Resident 2 began walking towards him stating, I'm waiting to get you next. LVN 1 stated once Resident 1 regained consciousness, Resident 1 was observed with swelling to the forehead, and stumbled upon standing. LVN 1 stated Resident 1 was transferred to the GACH immediately, while Resident 2 was taken into police custody. LVN 1 stated Resident 2 had been refusing Haldol. LVN 1 stated the risk of resident refusing antipsychotic medications could result in aggressive residents and a possibility of a resident to abuse/assault other residents and staff. During an interview, on 4/25/2025 at 11:58 a.m., LVN 2, LVN 2 stated, on 4/19/2025 around 8:34 a.m., she observed a staff member rushing a crash cart over to Resident 1. LVN 2 stated as she ran to the patio hallway, she observed Resident 1 on the floor, unconscious. LVN 2 stated when Resident 1 regained consciousness, he began bleeding from his nose. LVN 2 stated the ambulance arrived at the facility within 2 minutes after 911 was called and was transferred to the GACH due to the injuries he sustained from Resident 2. During an interview on 4/25/2025 at 12:58 p.m., with the Registered Nurse Supervisor (RNS), the RNS stated Resident 2's refusal of Haldol resulted in sudden aggression and a physical altercation towards Resident 1. During a review of the facility's policy and procedures (P&P), titled Identifying Abuse, revised 9/2022, the P&P indicated, Abuse of any kind against residents is strictly prohibited. The P&P indicated Physical abuse includes, but is not limited to hitting, slapping, biting, punching or kicking.