| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055211 | A. Building<br>B. Wing | 07/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Idylwood Care Center | 1002 W. Fremont Avenue<br>Sunnyvale, CA 94087 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, the facility failed to follow its fall policy and procedure, FALL PREVENTION & MANAGEMENT, when staff did not assess, report, and document a fall for one out of three residents (Resident 1) when Resident 1 consistently reported falling and that staff helped her back to bed approximately a week ago; however, the reported fall was not handled according to the facility fall policy for assessment, documentation, post fall monitoring, and physician notification. Subsequent medical evaluation results identified injury the right great toe. This deficient practice left Resident 1 without timely interventions for her fall injuries, which was a change of condition, by the facility.Findings: Review of a facility self-report, dated 6/12/26, indicated, On 6/10/26 during AM shift, Resident 1 had a change in condition of swelling with skin discoloration on the left foot and skin discoloration on the right foot. When the charge nurse asked Resident 1 what happened, Resident 1 claimed that a week ago she tried to stand and fell on the floor mattress. Review of Resident 1's face sheet (document summarizing a resident's personal health information) indicated Resident 1 was admitted on [DATE] with a diagnosis of age-related osteoporosis without current pathological fracture and was self-responsible. Review of Resident 1's comprehensive Minimum Data Set (MDS, an assessment tool used at skilled nursing facilities) dated 3/27/26, indicated she has good short term and long-term memory. The Quarterly MDS dated [DATE] indicated Resident 1 had good short-term memory. During a concurrent observation and interview in Resident 1's room on 06/30/26 at 10:07 a.m., Resident 1 was lying in bed awake with a floor mattress on the floor next to the bed. Resident 1 stated before her foot injuries were discovered, she had a fall the week before. Resident 1 stated when she tried to stand up, she heard crackles (popping noise) from her foot and fell on the floor mattress. Resident 1 stated staff helped her back to bed. Review of Resident 1's Change of Condition (COC) notes, dated 6/10/26 at 12:52 pm, indicated, Resident said, a week ago she tried to stand and fell on her mattress. She was assisted back to bed; she was initially fine and now she has a pain 10/10 on her foot. During review of Resident 1's Emergency Department (ED) record, dated 6/10/26, a Collected collateral hx (history) from EMS (Emergency Medical Services) HPI (History of Present Illness) indicated, . according to collateral and nursing facility staff, patient tripped and fell over her feet. while getting up out of bed. Patient stated his happened a week ago. Has pain to the right big toe. Further review of Physical Exam: Neurological: Mental Status: Residents 1 was alert, oriented to person, place and time. A Radiology Result Report, dated 6/10/26, indicated, FOOT COMPLETE MIN 3V, RIGHT (X-ray of the complete right foot using at least three different picture angles): Findings: There is minimally displaced intra-articular fracture (a bone break that extends into the surface of a joint, crossing through the articular cartilage) of the lateral base of the first proximal phalanx (bone closest to the great toe). CONCLUSION: Fracture of the first proximal phalanx, as above. FOOT COMPLETE MIN 3V, LEFT: Findings: No acute fracture. No dislocation. Moderate degenerative changes are present. Bones are osteopenic. Soft tissues are unremarkable. CONCLUSION: Moderate degenerative changes without acute abnormality. Review of Resident 1's interdisciplinary team (IDT, healthcare staff from various departments within a skilled nursing facility convening together to<br>(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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | discuss patients' care), documentation of 6/12/26 for Resident 1's unwitnessed fall on 6/10/26 indicated, Per resident she got up from her bed and tried to walk, but fell and landed on her floor mattress. but was assisted back to bed by 4 staff. During a follow up interview of Resident 1 on 7/1/26 at 11:15 a.m., Resident 1 stated she tried standing up and had a fall onto the bedside floor mattress and heard a crackle, and then a big and tall staff grabbed her shoulder to assist her back to bed. During an interview with LVN C on 7/1/26 at 1:01 p.m., LVN C, who was the assigned nurse, stated, Resident 1 complained of pain. the dorsal area of her foot was swollen and discolored. LVN C stated Resident 1 tried to stand up had a fall. she was assisted back to the bed by nursing assistants. I don't know by whom . she needs assist by Hoyer lift (mechanical lift used to transfer a patient). LVN C stated when Resident 1 was asked if she was able to get back to bed, Resident 1 answered No. During an interview with LVN D on 7/1/26 at 1:49 p.m., LVN D stated he was the assigned nurse supervisor that assessed Resident 1 on 6/3/26 and no incident occurred during his shift. LVN D stated, however, on 6/10/26, Resident 1's assigned nurse informed him about Resident 1's skin discoloration. LVN D stated he went to investigate. LVN D stated Resident 1 reported that a week ago, I got up and fell on the floor mattress. LVN D asked Resident 1 who caried her back to bed, and she stated, You carried me back to bed. LVN D stated the resident is total assist and uses a Hoyer lift. During an interview with the Assistant Director of Nursing (ADON) on 7/1/26 at 2:29 p.m., she stated, upon knowledge of Resident 1's foot discoloration, they investigated it as an injury of unknown source. The ADON stated Resident 1 reported she had a fall and multiple people helped her. The ADON stated Resident 1 needs total assist and a mechanical lift. During an interview with the Assistant Director of Nursing (ADON) on 7/1/26 at 3:55 p.m., she stated, When a resident falls and sits on a mattress, we treat it as a fall. we do the assessment, we do a care plan, we talk as a team to discuss interventions . we investigate it. Review of the facility's policy and procedure titled, FALL PREVENTION & MANAGEMENT, revised date 09/01/13, indicated, It is the goal of this facility to prevent or reduce the occurrence of falls and severity of fall-related injuries. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Procedure for responding to a fall: 1. Resident to be immediately evaluated by a licensed nurse at the location of the fall. Assessment should include, but not limited to, an evaluation of ABC, signs of bleeding, trauma, physical injury, head injury, muscular or skeletal trauma, an evaluation of pain, and vital signs. Assist resident to a comfortable position as tolerated, paying attention to verbal & non verbal indicators of pain /discomfort. 2.Nurses are to intervene according to symptoms and clinical manifestations. It may be necessary to provide oxygen, emergency first -aid, or ambulance via 911 transport depending on the severity of the situation and advance directives. 3. Physicians is to be notified as soon as practicable following the fall. Collaborative effort is needed in the event, and injury has occurred or is suspected. 4. An X-ray should be ordered by the physician to R/O (rule out) fracture when it is suspected by indicators of pain, redness, swelling, shortening and/ or external rotation of a lower extremity. (Remember that in most fall incidents, Fall+Pain=X-ray). 5. Resident is to be placed on observation of vital signs, pain, and other post-fall complications. Fall details, assessment findings, interventions, & notifications are to be documented in resident's clinical record & care plan updated accordingly. 6. Continued monitoring is necessary, as symptoms may present at the time, even days following the actual event. Promptly notify the MD about abnormal symptoms.7. Residents with an unwitnessed fall, (who are not oriented enough to give an accurate history), and an actual or suspected head injury will have neurological check implemented and documented per neuro check policy. 8. Follow up vital signs, assessment, pain evaluation, and neurological check (when indicated) will be conducted for a minimum of 72 hours for any actual or suspected fall, with or without injury. 9. Recent falls will be reviewed each week by the interdisciplinary team to evaluate trends, identity educational needs, and determine strategies to prevent recurrence for each resident. |