STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055737	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Hills Post Acute	12200 LA Mirada Blvd. LA Mirada, CA 90638

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 - Immediate jeopardy to resident health or safety 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** 45009 Based on observation, interview, and record review, the facility failed to provide supervision to one of two sampled residents (Resident 1) identified as an elopement (the act of leaving a facility unsupervised and without prior authorization) risk by failing to: 1. Follow its policy and procedures (P&P) titled Accidents and Supervision, which indicated the facility will implement interventions to prevent injury to residents. 2. Follow its P&P titled Elopements and Wandering Residents, which indicated residents with a risk for elopement would receive supervision to prevent accidents. 3. Utilize a systematic approach to monitoring and managing Resident 1 to prevent the resident from leaving the facility unsupervised. 4. Ensure door locks/alarms were in place to prevent Resident 1 from eloping. 5. Ensure the facility's exit doors were monitored to prevent Resident 1 from leaving the facility unsupervised. These deficient practices resulted in Resident 1 eloping from the facility, falling and sustaining fractures (broken bone) to the nose, mandible (jawbone), 6th to 8th right ribs, a lip laceration (cut), a bump on the right side of the head, an injured right knee, and broken upper dentures and lower teeth implants. On 4/22/2025 at 3:47 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation caused, or was likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (Admin) due to the facility's failure to provide supervision to Resident 1, in-servicing staff on supervision for residents with elopements risks and complying with rules and regulations to prevent accidents and elopements. On 4/24/2025 at 4:09 p.m., the facility submitted an acceptable IJ Removal Plan (IJRP). After verification of the IJRP implementation through observation, interview, and record review, the IJ was removed onsite on 4/24/2025 at 4:19 p.m., in the presence of the Admin. (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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJPR included the following immediate actions: 1. Resident 1 was transferred to the hospital for evaluation and assessment. Resident 1 returned to the facility on [DATE] and was placed on 1:1 supervision (staff member providing continuous and constant observation to a single resident). 1:1 staff was provided supervision education. Resident 1 will be on 1:1 indefinitely until a safe plan can be put in place or the interdisciplinary team (IDT, group of different disciplines working together towards a common goal of a resident) has determined 1:1 supervision is no longer indicated. 2. On 4/6/2025, the Admin provided in-service education to the weekend and evening receptionist regarding not leaving their post unattended. 3. On 4/5/2025, the Director of Staff Development (DSD) and Admin provided in-service regarding the monitoring/supervision, wandering and elopement policy to the receptionist and facility staff who were on shift such as: licensed nurses, certified nursing assistants (CNAs), therapists, environmental services, social services, activities, dietary services, and administrative personnel. 4. On 4/5/2025, facility doors were checked for appropriate function by the Maintenance Director. 5. On 4/5/2025, a head count was initiated of in-house residents by the Admin and found that all residents totaling 132 were accounted for. 6. Elopement assessments were completed on all residents by the Director of Nursing (DON)/designee on 4/5/2025, and 4/6/2025. 7. Two residents identified to be at risk for elopement were reviewed by the DON/designee for appropriate care plan interventions initiated on 4/5/2025. 8. An in-service education regarding wandering and elopement was provided by Administrator/ DON/ Designee to facility staff: facility licensed nurses, CNAs, therapists, environmental services, social services, activities, dietary services, and administrative personnel was initiated on 4/5/2025. Staff who are on leave or as needed (PRN) will be in-serviced on their next scheduled shift. 9. On 4/6/2025, an IDT meeting was conducted for the two residents who are identified as at risk for elopement. 10. The DON or designee will audit new admissions with elopement risks and ensure appropriate interventions are in place for three months or until substantial compliance is achieved. 11. Weekly, the Social Services Director (SSD) or designee will review all new admissions to ensure an elopement risk assessment has been completed, and those residents identified at risk are updated in the Elopement binder. Audits will be conducted for three months or until substantial compliance is achieved. 12. New hires will receive education on wandering, elopement, and resident safety by the DON, SSD, or designee(s) upon hire and annually thereafter. Facility will continue to perform on going in-service trainings regarding wandering, elopement, resident safety, and resident monitoring/supervision to facility staff monthly for 3 months. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. Elopement risk binders were reviewed by the DON and Administrator on 4/6/2025 and were up to date. Elopement risk binders are available at each nursing station and at the reception area. Elopement binders are updated by the SSD Monthly and PRN with oversite by the DON. 14. Elopement code drills were initiated on all shifts starting on 4/6/2025 and will continue to perform drills monthly for three months; then quarterly thereafter by Administrator/DON and/or DSD. 15. An ongoing weekly check of facility doors and alarms were performed by the Maintenance Department to ensure function and securement. An increase to twice weekly frequency of facility door and alarm checks were initiated on 4/6/2025. 16. An ongoing twice weekly check of facility doors and alarms will be performed by the Maintenance Department to ensure function and securement for three months or until substantial compliance has been achieved. Any findings will be corrected immediately and trends reported to the Quality Assurance/Quality Assurance and Performance Improvement (QA/QAPI- a data driven proactive approach to improvement used to ensure services are meeting quality standards) Committee for further recommendations. 17. The QAPI Committee will review and discuss elopement and supervision for all residents during the monthly QAPI meetings to determine the effectiveness of the facility's efforts and to provide feedback and program modification for a minimum of three months or until pattern of compliance is maintained. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History and Physical (H&P) dated 11/19/2024, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2025, the MDS indicated Resident 1's cognitive skills for daily decision making (ability to think, remember and reason) were impaired. The MDS indicated Resident 1 required moderate assistance (helper does less than half) for toileting hygiene, dressing, and personal hygiene. The MDS indicated Resident 1 required supervision for oral hygiene and putting on/taking off footwear. The MDS indicated Resident 1 required set up or clean up assistance for eating. The MDS indicated Resident 1 required moderate assistance to walk 50 feet with two turns. The MDS indicated Resident 1 used a manual wheelchair for mobility. The MDS indicated Resident 1 had the ability to wheel herself at least 150 feet. During a review of Resident 1's Care Plan titled, Risk for elopement, dated 2/5/2024, the care plan indicated the goal was for Resident 1 to remain in the facility with no episodes of elopement. The interventions indicated to anticipate Resident 1's needs, encourage daily activity participation, and frequent visual checks for needs and safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Elopement Risk assessment, dated 8/29/2024, the elopement risk assessment indicated Resident 1 had wandering behaviors and a history of attempting to leave the facility without informing staff. During a review of Resident 1's Situation, Background, Assessment, and Recommendation form ([SBAR], used for information transfer, especially when discussing critical situations or changes in a patient's condition), dated 4/5/2025, the SBAR indicated on 4/5/2025, Resident 1 had a fall in the street. The SBAR indicated Resident 1 stated she fell from the wheelchair and landed on her face. The SBAR indicated Resident 1 had right forehead swelling, a cut to the right lower lip, and blood noted. During a review of Resident 1's General Acute Care Hospital (GACH) H&P Report dated 4/5/2025 at 5:29 p. m., the report indicated Resident 1 had a ground level fall and sustained a right jawbone and nasal (nose) bone fractures and was admitted to the GACH for syncope (a brief loss of consciousness caused by a temporary decrease in blood flow to the brain) and fall. During a review of Resident 1's GACH Computed Tomography ([CT], non-invasive imaging technique that uses X-rays [electromagnetic radiation that can penetrate through objects and create images on film] to create cross-sectional images of the body) results of the face dated 4/5/2025, the CT results indicated Resident 1 had nondisplaced (a break in a bone where the bone fragments remain aligned) lateral (a side part of something) and inferior (a break or crack in the bones surrounding the left maxillary sinus on the lateral and inferior sides) wall fractures of the left maxillary sinus (one of two paranasal sinuses [a hollow space in the bones around the nose], located in the maxillary bone, which is part of the upper jaw, on the left side of the face), a nondisplaced left nasal bone fracture, and right facial and scalp soft tissue injury (damage to the non-bony structures of the body, such as muscles, ligaments, tendons, and nerves). During a review of Resident 1's GACH Discharge Summary dated 4/6/2025 at 11:34 a.m., the discharge summary indicated Resident 1's diagnosis were facial fractures and rib fractures. The discharge summary indicated blood was noted on Resident 1's nose and lower lip and a right parietal hematoma (scalp hematoma [a localized collection of blood outside of blood vessels, typically caused by injury or trauma] outside of the brain). The discharge summary indicated Resident 1 had an acute buckle fracture (one side of a bone bulges out, or buckles, without breaking through the entire bone) at the anterolateral (both anterior and lateral) right 6 - 8th ribs. During an interview on 4/18/2025 at 10:00 a.m. with Resident 1, Resident 1 stated on 4/5/2025, (time unknown) she fell and hurt herself. Resident 1 stated she did not remember where she fell . Resident 1 stated she injured her right knee, and it was very painful. Resident 1 stated after her fall she had bruises on her face and a cut on her right knee. Resident 1 stated her fall caused her dentures and implants to break. During an interview on 4/18/2025 at 10:28 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 4/5/2025 at 9:45 a.m., she was notified by Licensed Vocational Nurse (LVN) 1 that Resident 1 wanted to use the restroom. CNA 1 stated she assisted Resident 1 to the commode (a portable toilet, one with a chair like frame), and back on her wheelchair and then she wheeled the resident to the hallway, in front of her room. CNA 1 stated she left Resident 1 sitting on her wheelchair in front of her room and went to assist other residents. CNA 1 stated that was the last time she saw Resident 1. CNA 1 stated at 10:05 a.m., Resident 1 was missing and could not be located. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/18/2025 at 11:10 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 4/5/2025 at 9:30 a.m., she saw CNA 1 wheel Resident 1 outside her room. LVN 1 stated at 9:40 a.m., she saw Resident 1 propel herself down the hallway. LVN 1 stated between 10:00 a.m., and 10:45 a.m., a staff (unnamed) questioned if she had seen Resident 1. LVN 1 stated Resident 1 was found outside by a church parking lot, located adjacent to the facility. LVN 1 stated the CNAs should know to take Resident 1 to the activities or sunshine room (a room where residents watch tv, read, or do activities) to keep Resident 1 busy from wandering behaviors. During an interview on 4/18/2025 at 1:10 p.m. with Resident 1's Responsible Party (RP 1), RP 1 stated on 4/5/2025 at 10:55 a.m., staff informed her Resident 1 left the facility unsupervised. RP 1 stated she was told Resident 1 propelled herself to the adjacent property (church), went down the church's driveway and fell off her wheelchair and landed on the street. RP 1 stated the facility informed her a good Samaritan (someone who gives help to people who need it) who was driving by, stopped and called 911 (Universal Emergency Number, for citizens throughout the United States to request emergency assistance) to assist Resident 1. RP 1 stated Resident 1 sustained fractures to her nose, mandible, three right rib fractures, laceration on the upper lip, and bruising on her face, under the right breast and on her right knee. RP 1 stated she was notified by the emergency medical technician (EMT, a medically trained individual who provides emergency medical care to patients before they are transported to a hospital) that Resident 1 was found in the lane closest to the curb bleeding from her face. RP 1 stated the EMT informed her the good Samaritan blocked incoming traffic with her vehicle and called 911. During an interview 4/18/2025 at 2:15 p.m. with the Director of Staff Development (DSD), the DSD stated on 4/5/2025, CNA 3 asked her (DSD) if she had seen Resident 1 because the resident was missing. The DSD stated she went outside to look for Resident 1 and found the resident on the street near the sidewalk. The DSD stated Resident 1 had fallen out of her wheelchair and had a cut on her lower lip. The DSD stated a civilian stopped her vehicle to help Resident 1 and called 911. The DSD stated she interviewed the facility's Receptionist to determine how and when Resident 1 left the facility unsupervised. The DSD stated the Receptionist told her she did not see Resident 1 leave the facility. The DSD stated the Receptionist stated she left the front desk unattended to use the restroom. The DSD stated Resident 1 was at risk for falls and elopement and should have been always monitored. During an interview on 4/18/2025 at 2:45 p.m. with CNA 2, CNA 2 stated on 4/5/2025 at 10:00 a.m., he was notified by Resident 2 that 20 minutes prior he saw Resident 1 leave through the facility's front doors. CNA 2 stated he began to look for Resident 1 and went outside to the parking lot and then the street where he observed a lady waving him down. CNA 2 stated the lady was standing in the middle of the street and stopped traffic with her vehicle. CNA 2 stated the lady told him not to touch Resident 1 and that she called 911. CNA 2 stated he observed Resident 1 on the ground, in the middle of the street lying on her right side. CNA 2 stated he observed a lot of blood on the ground and on Resident 1's face. CNA 2 stated Resident 1 was not talking. During an interview on 4/18/2025 at 3:30 p.m. with Registered Nurse (RN) 1, RN 1 stated on 4/5/2025 at 10:05 a.m. she heard Resident 1 was missing. RN 1 stated she went outside and saw Resident 1 sitting on the street near the sidewalk. RN 1 stated Resident 1 had blood on her face. RN 1 stated she stayed with Resident 1 until the EMTs transported Resident 1 to the GACH. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/18/2025 at 3:54 p.m., with the Admin, the Admin stated on 4/5/2025 at 10:30 a.m., the DSD notified her Resident 1 left the facility unsupervised and had a fall. The Admin stated Resident 1 should have been supervised every 30 minutes by staff to prevent Resident 1 from elopement, falls, and injuries. The Admin stated the Receptionist walked away from the front desk when Resident 1 eloped from the facility. The Admin stated there was supposed to be a person sitting at the front desk at all times to prevent residents from leaving the facility unattended. The Admin stated the Receptionist should have notified someone to relieve her before leaving the front desk. During an interview on 4/18/2025 at 4:24 p.m., with the DSD, the DSD stated all staff were responsible for monitoring Resident 1. The DSD stated Resident 1 needed to be monitored every hour on her whereabouts. The DSD stated the Receptionist should not leave the front desk unattended. The DSD stated the Receptionist should have notified someone to stay at the front desk to prevent residents from elopement and injuries. During a concurrent observation and interview on 4/21/2025 at 9:35 a.m., with CNA 2, in the facility's adjacent property's parking lot, CNA 2 pointed to the middle of the street as the location where he found Resident 1 on 4/5/2025 laying on her right side. CNA 2 stated he walked out of the facility down the driveway, and to his left he saw a lady flagging him down, waving her arms up and down. During an interview on 4/21/2025 at 12:50 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was an elopement risk. The DON stated an elopement risk meant it was a risk to have Resident 1 alone in an unsupervised area and Resident 1 was not to leave the facility without supervision. The DON stated it was not safe for Resident 1 to be unsupervised in the parking lot because she was confused and could potentially fall and sustain injuries. The DON stated all staff were responsible to supervise Resident 1. The DON stated the reason Resident 1 eloped from the facility and sustained injuries was due to lack of supervision. The DON stated it was important to continuously monitor a resident with an elopement risk for the residents' safety. During an interview on 4/21/2025 at 2:46 p.m. with Resident 2, in Resident 2's room, Resident 2 stated on 4/5/2025 at 9:30 a.m. Resident 1 was sitting at the front lobby and he was sitting out on the patio. Resident 2 stated he saw Resident 1 leave through the facility's front exit door, which was wide open. Resident 2 stated Resident 1 propelled herself out the door and no one noticed her leave. Resident 2 stated he thought Resident 1 was going to come back but she did not. Resident 2 stated he notified the Receptionist that Resident 1 left the facility. Resident 2 stated the Receptionist went outside to look for Resident 1 but did not find her and she came back into the facility to inform staff Resident 1 was missing. Resident 2 stated 20 minutes after Resident 1 left the facility he also notified CNA 2 that Resident 1 exited through the facility's front door and staff started to look for Resident 1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/24/2025 at 12:21 p.m. with the DON, the DON stated Resident 1 was supposed to be monitored every 5 minutes to prevent the resident from leaving the facility unsupervised. The DON stated there was a lapse in supervision which was the reason why Resident 1 was able to wheel herself out of the facility unnoticed. The DON stated staff were not vigilant in responding to the door alarms in a timely manner. The DON stated there was a delay in staff responding to the front exit door alarm because Resident 1 could have been found right outside the facility. The DON stated the facility's front exit door was not monitored when Resident 1 left the facility. The DON stated all staff should have redirected Resident 1 to another area or involve Resident 1 in activities. The DON stated it was important to follow the facility's monitoring approach in preventing elopement, accidents, and injuries for residents' safety. The DON stated it was important to make sure door alarms were working, monitored, and staff responded to the alarms promptly to prevent elopements and accidents. During a review of the facility's Policy and Procedure (P&P) titled Elopements and Wandering Residents, undated, the P&P indicated the facility would ensure residents who exhibit wandering behavior and/or are at risk for elopement received adequate supervision to prevent accidents. The P&P indicated the facility was equipped with door locks/alarms to help avoid elopements. The P&P indicated staff would be vigilant in responding to alarms in a timely manner. The P&P indicated adequate supervision would be provided to help prevent accidents or elopements. During a review of the facility's P&P titled Accidents and Supervision, dated 12/19/2022, the P&P indicated residents would receive adequate supervision to prevent accidents. The P&P indicated supervision was an intervention and a means of mitigating accident risk. The P&P indicated the facility would establish and utilize a systemic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.