STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056488	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Nursing Center	22617 S. 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 - Minimal harm or potential for 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** Based on interview and record review the facility failed to ensure that required fall-prevention interventions were implemented for one of three residents (Resident 1) by failing to:1. Implement the Falling Star Program (is a fall prevention initiative used to identify and alert staff, that a patient or resident is at high risk of falling) upon admission.2. Ensure the use of floor mats (safety devices, often specifically designed to be low-profile and impact-absorbing, used to help prevent falls and reduce the severity of injuries if a fall occurs).3. Obtain a bed alarm (a safety device for residents at risk of falling, typically a pressure-sensitive pad placed on the bed).4. Revise Resident 1's care plan after the first fall.5. Notify the physician of Resident 1's unsafe behavior (repeatedly attempting to get out of bed). These failures resulted in Resident 1 having two avoidable falls on 11/7/2025 and 11/8/2025. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (loss of memory, language, problem-solving and other thinking abilities), anemia (a condition in which there is lack of enough red blood cells), and dysphagia (difficulty swallowing). During a review of Resident 1's History and Physical (H& P) dated 11/7/2025, 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]resident assessment tool) dated 9/17/2025, the MDS indicated Resident 1 required Substantial/maximal assistance (Helper does more than half the effort) for toileting hygiene, shower/bath, and personal hygiene. During a review of Resident 1's Interdisciplinary Team ([IDT]a group of professionals from various specialties who collaborate to provide comprehensive and coordinated patient care) Conference Record, dated 9/15/2025, the IDT Record indicated, Resident 1 is at risk for falls due to deconditioning (decline in physical function and muscle strength) and weakness.During a telephone interview on 11/18/2025 at 9:21 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 fell on [DATE] at 5:00 p.m. CNA 1 stated Resident 1 appeared more disoriented (to feel lost or confused) than usual and repeatedly attempted to get out of bed. CNA 1 stated that she notified the charge nurse of these changes. CNA 1 stated that she is not familiar with the facility's policy regarding procedures to follow when a resident experiences a fall. CNA 1 acknowledged that Resident 1 did not have floor mats present at the time of her fall. CNA 1 stated if a resident is identified as a fall risk, the following interventions should be in place: the bed should be in the lowest position, the resident should be wearing a yellow armband, a yellow star should also be placed at the head or foot of the bed, floom mats should be present, and bed alarms, if indicated, should be in place and functioning. CNA 1 stated if these interventions are not implemented, a resident could be at higher risk for falling and getting hurt, such as slipping out of bed without staff noticing in time or sustaining an injury due to the absence of floor mats or lack of timely response from staff.During a concurrent interview and record review on 11/18/2025 at 10:05 a.m. with License Vocational Nurse (LVN) 1, Resident 1's Morse Fall Scale, (a simple tool used by healthcare professionals to quickly assess a patient's risk of falling) dated 9/11/2025 was reviewed. The Morse Fall Scale indicated Resident 1's score was 65.0, indicating high risk for falls. LVN 1 stated that she (continued on next page)

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

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LVN 1 stated that the physician was not notified about Resident 1's behavior. LVN 1 stated the only fall precaution that was in place prior to Resident 1's fall was the bed was in a low position. LVN 1 stated that she informed Resident 1's representative that the facility was unable to obtain a sitter or a bed alarm for Resident 1 because a physician order was required. LVN 1 stated that she offered to provide floor mats as an intervention; however, she was unable to obtain the floor mats at that time. LVN 1 stated that she did not contact the physician at the time to try to obtain a sitter or bed alarm and reported that she did not have a reason for why the physician was not contacted. LVN 1 acknowledged that the physician should have been notified to obtain the necessary orders for additional safety interventions. LVN 1 stated that a potential outcome of not having these interventions in place is that the resident could fall and get injured because staff may not know right away that the resident is getting out of bed. During a telephone interview on 11/18/2025 at 11:06 a.m. with Registered Nurse Supervisor (RNS), the RNS stated that her role is to oversee residents that are at high risk for falls, which includes implementing fall-prevention precautions and carrying out the facility's Falling Star Program. The RNS stated that this program includes ensuring that the residents' bed is in the lowest position, floor mats are in place, bed alarms are used if needed, and frequent monitoring. RNS stated that prior to Resident 1 falling, that the resident was yelling, attempting to hit staff, and repeatedly attempting to get out of bed. RNS acknowledged that these behaviors represented a change in condition ([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, and that the physician should be notified of such changes so that the resident's care plan can be revised and updated. The RNS stated that she did not notify the physician of the resident's change in condition prior to the fall, and she did not complete a change in condition assessment after the resident began exhibiting increased confusion. The RNS stated that failure to notify the physicians could result in the residents not receiving timely medical interventions, which may lead to further decline, increased risk of injury, or additional adverse events. The RNS acknowledged that this could negatively impact the residents' overall safety and well-being. The RNS validated that Resident 1 did not have floor mats at the time of her fall. RNS stated that she did not think about the resident not having floor mats. The RNS stated that Resident 1 should have floor mats in place, as floor mats are part of the Falling Star Program for residents identified as high risk for falls. The RNS acknowledged that the absence of floor mats could increase the risk of injury if the resident attempted to get out of bed or fall, as the mats provide an added safety measure to reduce potential harm. During a concurrent interview and record review on 11/18/2025 at 12:54 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Care Plan dated September 2025 was reviewed. The Care Plan indicated, Resident is high risk for fall but the facility's Falling Star Program interventions were not initiated until 11/10/2025. The ADON stated the Falling Star Program was not initiated for Resident 1 upon admission in September 2025, despite the resident being identified as a fall risk on the care plan. The ADON stated the failure to implement the program could have resulted in a negative outcome, as Resident 1 sustained two falls on 11/7/2025 and 11/8/2025. The ADON stated she did not know why the Falling Star Program was not initiated at the time of Resident 1's admission. The ADON stated upon admission and readmission, all residents should be assessed for their fall risk by utilizing the Morse Fall Scale. The (continued on next page)

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