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	06/16/2025

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** Based on interview and record review, the facility failed to implement their policy and procedure (P/P) titled Care Plans, Comprehensive Person-Centered, 1. to conduct an Interdisciplinary Team ([IDT] group of healthcare professionals, including resident/ resident representative, working together to provide residents with needed care) and 2. to document a post fall care plan for one of four sampled residents (Resident 2) after sliding out of the wheelchair and onto the floor. This failure resulted in Resident 2, who is non-verbal and bedbound, having another fall on 06/04/2025 of sliding out of the bed and onto the floor and staff returning Resident 2 to bed without informing the charge nurse or supervisor, and without having a qualified staff assess for injuries. This failure also resulted in Resident 2 sustaining a fractured femur (a break in the femur, the long bone in the thigh, and is a serious injury), enduring hours of pain and transferring to the general acute care hospital (GACH). Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including right knee osteoarthritis (breakdown of joint cartilage, leading to pain, stiffness, and limited movement in the affected joints), hypertension (high blood pressure), and ataxia (loss of muscle coordination). During a review of Resident 2's Change of Condition (COC), dated 11/12/2024 at 5 p.m., the COC indicated Resident 2 was seen up in her wheelchair, in the hallway and was propelling self forward. The COC indicated Resident 2 reached for the hallway handrail, pulled self forward down the hallway and slowly sled out of her wheelchair and sat on the floor. During a review of Resident 2's post fall Fall Risk Assessment, dated 11/12/2024, the post Fall Risk Assessment indicated Resident 2 has a high risk/potential for falls. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 4/15/2025, the MDS indicated Resident 1 had cognitive impairment. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with 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

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	06/16/2025

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	During an interview on 6/16/2025 at 12 noon, with the Medical Records Director, in the Medical Records office, the Medical Records Director stated Resident 2 did not have a post fall IDT notes and post fall care plan after the 11/12/2024 fall. The Medical Records Director stated the nurses were responsible for formulating the post fall care plan and documenting in the IDT meeting notes. The Medical Records Director stated failure to conduct an IDT meeting and create the post fall care plan may jeopardize Resident 2's safety. During an interview on 6/16/2025 at 12:20 p.m., with the Director of Nursing (DON), the DON stated the Registered Nurse Supervisor was responsible for conducting an IDT meeting and documenting the IDT meeting notes and updating and documenting the fall care plan. The DON stated that failure to conduct an IDT meeting and document IDT meeting notes and update the fall care plan is a lack of documentation. The DON failed to verbalize how the lack of documentation would affect Resident 2's care and safety. During a review of the facility's P/P titled Care Plans, Comprehensive Person-Centered, revised dated March 2022, the P&P indicated care plan must include developed measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and implemented for each resident. The P&P indicated interventions should be chosen after data gathering, proper sequencing or events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The P&P indicated the interdisciplinary team review and updates the care plan when there has been a significant change in the resident's condition and when the desired outcome is not met.

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	06/16/2025

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 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 one of four sampled residents (Resident 2), was assessed for pain after a fall incident on 6/5/2025. This failure resulted in the delay of pain assessment and interventions and had the potential for Resident 2 to suffer severe pain. Findings: During a review of Resident 2 ' s admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including right knee osteoarthritis (breakdown of joint cartilage, leading to pain, stiffness, and limited movement in the affected joints), hypertension (high blood pressure), and ataxia (loss of muscle coordination). During a review of Resident 2 ' s Minimum Data Set (MDS-a resident assessment tool) dated 4/15/2025, the MDS indicated Resident 1 had cognitive impairment. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with eating, toileting hygiene and personal hygiene. During a review of Resident 2 ' s Change of Condition (COC), dated 6/5/2025 at 2 a.m., the COC indicated Resident 1 had right leg pain when moved with facial grimacing. The COC indicated Resident 1 was unable to verbalize any pain. The COC indicated a nurse (unidentified) moved Resident 2 ' s all extremities and noted facial grimacing when right leg was moved. During an interview on 06/09/2025 at 1:10 p.m. with the Director of Nursing (DON), the DON stated the Charge Nurse did not assess Resident 2 ' s pain level after the fall because the assigned Certified Nursing Assistant (CNA 1) did not notify the Charge Nurse because the facility was having a recertification survey (an annual survey conducted to ensure compliance by healthcare facilities with the requirements for participation in Medicare and Medicaid programs). CNA 1 put Resident 2 back to bed by herself and watched for any pain and discomforts. During a telephone interview on 6/10/2025 at 2:40 p.m. with CNA 1, CNA 1 stated she was in the resident ' s bathroom preparing to provide morning care. CNA 1 stated she heard a sudden loud noise and found Resident 2 on the floor. CNA1 stated Resident 2 was nonverbal and nodded her head when asked indicating she was ok. CNA 1 stated she did not notify the Charge Nurse about the fall because she was nervous, and the facility had an ongoing recertification survey. CNA 1 stated failing to notify the Charge Nurse would have caused Resident 2 to suffer pain and delayed medical attention. During a review of the facility ' s undated policy and procedure (P&P) titled, Incidents/Accidents, the P/P indicated incidents/accidents should be reported to the charge nurse and documented on the accident/incident report as soon as they occur. The P&P indicated, the Charge nurse initiating the report will be responsible for the completeness and accuracy of the information contained in the report.