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	03/25/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the information on the Minimum Data Set (MDS - a resident assessment tool) related to Health Conditions, was accurately documented to reflect Resident 1's fall on 1/16/2026. This failure had the potential to result in inaccurate facility quality measures and could result in Resident 1 not receiving necessary care and services. Findings:During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses including traumatic subdural hemorrhage (a collection of blood in the brain caused by head trauma), repeated falls, restlessness and agitation.During a review of Resident 1's History and Physical (H&P) dated 1/10/2026, the H&P indicated Resident 1 had the mental capacity to understand but could not make medical decisions.During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment, no acute change in mental status, and no hallucinations or delusions. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) to transfer from lying to sitting on the side of the bed, transfer from sitting to standing, and to walk ten feet in his room. The MDS indicated Resident 1 did not have any falls since admission, reentry or the prior assessment.During a review of Resident 1's Change of Condition (COC - a communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/16/2026, the COC indicated on 1/16/2026 at 8:30 a.m., Resident 1 got out of bed to go to the bathroom without using the call light and his knees buckled which caused the resident to make contact with the floor. The COC indicated Resident 1 sustained a small bump and superficial cut to his nose with minimal bleeding. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1's short-term memory was intact and had no acute mental status change. The MDS indicated Resident 1 required moderate assistance (helper does less than half the effort) to transfer from lying to sitting on the side of the bed and to transfer from sitting to standing. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) to walk ten feet in his room. The MDS indicated Resident 1 did not have any falls since admission entry, reentry or the prior assessment.During a concurrent interview and record review on 3/25/2026 at 11:50 a.m., with the MDS Coordinator, Resident 1's COC dated 1/16/2026, Resident 1's MDS dated [DATE], and the Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2025 were reviewed. The MDS Coordinator stated the definition of a fall was any unintentional contact with the ground. The MDS Coordinator stated on 1/16/2026, Resident 1 sustained an unwitnessed fall and sustained a small bump and cut on his face. The MDS Coordinator stated the MDS assessment dated [DATE] should have reported Resident 1's fall but did not. The MDS assessment should have also reflected that Resident 1 had fallen since the prior assessment on 1/14/2026. The MDS Coordinator stated there was no significant error assessment to correct the inaccuracy. The MDS Coordinator stated MDS assessments guided the care planning process and the inaccuracy had the potential to result in Resident 1's care plans not addressing his fall on 1/16/2026. Resident 1's MDS was inaccurate, and this inaccuracy had the potential to result in inaccurate facility quality measures.During a concurrent interview and record (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review on 3/25/2026 at 3:30 p.m., with the Director of Nursing (DON), the facility's P&P titled, Charting and Documentation dated 7/2017 was reviewed. The DON stated facility assessments must be accurate and complete. The DON stated the P&P was not followed when Resident 1's MDS assessment did not indicate Resident 1's fall in the facility on 1/16/2026. During a review of the facility's P&P titled, Charting and Documentation dated 7/2017, the P&P indicated documentation in residents' medical records should be objective, complete, and accurate. The P&P indicated events, incidents, and accidents involving residents should be documented in the resident's medical record.During a review of the facility's P&P titled, Comprehensive Assessments, dated 3/2022, the P&P indicated comprehensive assessments were conducted to assist in developing person-centered care plans. The P&P indicated a significant error is an assessment where the resident's overall clinical status was not accurately represented and/or results in inappropriate plan of care and was not corrected via submission of a more recent assessment.

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(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 implement their Policy and Procedure (P&P) titled, Safety and Supervision of Residents which indicated the facility would ensure interventions to reduce accident risks would be implemented for one of three sampled residents (Resident 1) by failing to provide one on one sitter (1:1- one staff delegated to supervise a single resident) for Resident 1 according to the residents care plan and Physician's Order.This failure resulted in Resident 1 sustaining an unwitnessed fall on 1/16/2026 and had the potential to cause injuries or hospitalization for the resident. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted on [DATE] with diagnoses including traumatic subdural hemorrhage (a collection of blood in the brain caused by head trauma), repeated falls, restlessness and agitation.During a review of Resident 1's Rehab Fall Risk Assessment, dated 1/9/2026, the assessment indicated Resident 1 required extensive assistance to perform bed mobility and transferring tasks. The assessment indicated Resident 1 used a wheelchair and did not use proper safety while using the assistive device. The assessment indicated Resident 1 did not use the call bell properly, did not demonstrate safety techniques during transfers, and did not show sufficient strength and correct posture in sitting or standing.During a review of Resident 1's History and Physical (H&P) dated 1/10/2026, the H&P indicated Resident 1 had the mental capacity to understand but could not make medical decisions.During a review of Resident 1's Physician Orders dated 1/13/2026, the orders indicated Resident 1 required 1:1 monitoring every shift due to the resident constantly attempting to get out of bed unassisted.During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 1/14/2026, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment, no acute change in mental status, and no hallucinations or delusions. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) to transfer from lying to sitting on the side of the bed, transfer from sitting to standing, and to walk ten feet in his room. During a review of Resident 1's Care Plan titled, Resident non-compliance manifested by: unassisted transfers. Resident at risk of fall/injuries related to unassisted transfers from bed.has frequent episodes of self-transfers from bed, dated 1/14/2026, the care plan indicated Certified Nursing Assistants (CNA) would provide a 1:1 sitter for Resident 1.During a review of Resident 1's Census tab, dated 1/14/2026, the Census indicated Resident 1 was assigned to Room A from 1/14/2026 through 1/26/2026.During a review of the facility's Nursing Assignment for the 11:00 p.m.-7:00 a.m. shift dated 1/15/2026, the assignment did not indicate a 1:1 sitter was assigned to Room A. During a review of Resident 1's Progress Notes dated 1/15/2026 and 1/16/2026, the Progress Notes did not indicate 1:1 supervision was provided from 1/15/2026 at 11:00 p.m. through 1/16/2026 at 7:00 a.m.During a review of the facility's Nursing Assignment for the 7:00 a.m.- 3:00 p.m. shift dated 1/16/2026, the assignment indicated CNA 1 was assigned as a 1:1 sitter for Room A.During a review of Resident 1's Change of Condition (COC - a communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/16/2026, the COC indicated on 1/16/2026 at 8:30 a.m., Resident 1 got out of bed to go to the bathroom without using the call light and his knees buckled which caused the resident to make contact with the floor. The COC indicated Resident 1 sustained a small bump and superficial cut to his nose with minimal bleeding. The COC did not indicate Resident 1 had a 1:1 sitter present nor witnessed the fall incident.During a concurrent interview and record review on 3/25/2026 at 9:58 a.m., with CNA 2, Resident 1's Physician Orders dated 1/13/2026, and Resident 1's COC dated 1/16/2026 were reviewed. CNA 2 stated Resident 1 constantly tried to get out of bed without assistance and exhibited unpredictable behavior. CNA 2 stated Resident 1 had an order to always have a 1:1 sitter within reach of the resident for every shift from 1/13/2026 through 1/31/2026. CNA 2 stated Resident 1 needed a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitter to prevent falls, minimize injuries, and witness accidents. CNA 2 stated Resident 1's sitter should have remained within reach of Resident 1 until the sitter was replaced by the next assigned CNA or another staff member. CNA 2 stated Resident 1 sustained an unwitnessed fall during change of shift on 1/16/2026 at around 7:00 a.m.During a concurrent interview and record review on 3/25/2026 at 11:50 a.m., with the MDS Coordinator, Resident 1's COC dated 1/16/2026 was reviewed. The MDS Coordinator stated the definition of a fall was any unintentional contact with the ground. The MDS Coordinator stated Resident 1 sustained an unwitnessed fall and sustained a small bump and cut on his face on 1/16/2026.During a concurrent interview and record review on 3/25/2026 at 12:20 p.m., with the Director of Nursing (DON), the DON stated Resident 1 needed a 1:1 sitter due to the Resident's high fall risk and impulsive behavior. The DON stated a sitter could have prevented Resident 1's fall and minimized injury.During an interview on 3/25/2026 at 3:57 p.m., with CNA 1, CNA 1 stated she was Resident 1's assigned sitter on 1/16/2026 from 7:00 a.m. through 3:00 p.m. CNA 1 stated Resident 1 was weak and required maximal assistance to get out of bed and walk to the bathroom. CNA 1 stated Resident 1 required a sitter because he was impulsive, did not call for help, had a history of falls, and was a high fall risk. CNA 1 stated there was no sitter from the previous shift or staff present in the room when she arrived at Resident 1 room on 1/16/2026 at 7:00 a.m. CNA 1 stated Resident 1 told her about a fall he experienced earlier that morning, and no staff were present to assist the resident or prevent the fall or injury.During a subsequent concurrent interview and record review on 3/25/2026 at 4:50 p.m., with the DON, the facility's Nursing Assignment for the 11:00 p.m.-7:00 a.m. shift dated 1/15/2026, was reviewed. The DON stated Resident 1 did not have a 1:1 sitter on 1/15/2026 from 11:00 p.m. through 1/16/2026 at 7:00 a.m. The DON stated Resident 1's physician orders and care plan were not followed when Resident 1 fell on 1/16/2026.During a review of the facility's P&P titled, Safety and Supervision of Residents, dated 7/2017, the P&P indicated the care team shall target interventions to reduce individual risks related to environmental hazards, including adequate supervision and assistive devices. The P&P indicated interventions to reduce accident risks should be implemented correctly and consistently.