STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555792	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Post-Acute Center	1291 S Bernardo Avenue 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 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 observation, interview, and record review, the facility failed to provide adequate supervision and implement fall prevention interventions for one of three sampled residents (Resident 1), when facility staff failed to monitor Resident 1 after lunch/activity and did not observe Resident 1 leave the dining/activity area. This failure resulted in Resident 1 having an unwitnessed fall in another resident's bathroom and placed Resident 1 at risk for potential injury. Findings: Review of Resident 1's face sheet (summary page of a patient's important information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including encephalopathy (damage or disease that affects the brain), cognitive communication deficit (problem with communication due to disruption in cognitive (thinking) processes), dementia with behavioral disturbance (includes agitation, aggression, anxiety, wandering, sleep disturbances, and psychosis (hallucinations or delusions), generalized muscle weakness, other reduced mobility (loss of ability to move freely or independently) and fall on same level.Review of Resident 1's Minimum Data Set (MDS, a standardized assessment tool), Section C, dated 5/22/26, indicated Resident 1 had a BIMS (Brief Interview for Mental Status) score of 3, indicating severe cognitive impairment.Review of Resident 1's MDS Section GG (function and mobility assessment) dated 6/8/26 indicated Resident 1 required substantial/maximal assistance with toileting hygiene and partial/moderate assistance with toilet transfers, sit-to-stand, and chair/bed-to-chair transfers. The MDS also indicated Resident 1 used a manual wheelchair and required assistance with mobility. Review of Resident 1's Fall risk Observation/assessment dated [DATE] indicated Resident 1 as high risk for falls with a score of 26 (high risk). The assessment also indicated Resident 1 had 1 to 2 prior falls, was dependent and incontinent.Review of Resident 1's Interdisciplinary Team (IDT, staff from different disciplines who work together to plan and provide care) note dated 5/28/26 indicated Resident 1 had an unwitnessed fall on 5/24/26 at 5:20 a.m. The IDT identified interventions including intermittent checking and safety protocol, frequent checks for bathroom assistance, and increased visual checks by CNAs (Certified Nursing Assistants) and nurses for safety. Review of Resident 1's Fall care plan, initiated on 5/24/26, indicated Resident 1 had an unwitnessed fall. The fall care plan included interventions for intermittent checking and safety protocol, frequent checks for bathroom assistance, and increased frequency of visual checks for safety by CNAs and nurses.Review of Resident 1's Change of Condition note dated 6/12/26 indicated Resident 1 had an unwitnessed fall in the bathroom and was found lying on his buttocks at approximately 1:00 p.m. The Note indicated vital signs were within normal limits. No visible trauma, wounds, or redness were noted. Resident complained of pain to the left arm/hand and left hip and denied head pain. The Nurse Practitioner (NP) assessed Resident 1, and the physician ordered X-rays (a medical imaging that uses radiation to take pictures of the inside of the body). The note indicated no injury was identified after the fall.During observation on 6/23/26 at approximately 1:30 p.m., Resident 1 was observed sitting in a wheelchair in the hallway in front of Resident 1's room. Resident 1 wore non-skid socks. Resident 1 was able to wheel himself in the hallway and attempted to stand from the wheelchair. Facility staff redirected Resident 1. During an interview with CNA A on 6/23/26 (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
	555792	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Post-Acute Center	1291 S Bernardo Avenue 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 2:08 p.m., the CNA assigned to Resident 1 that day. CNA A stated she toileted Resident 1 around 9:00 a.m., before lunch, and after lunch.During an interview with CNA B on 6/23/26 at 2:30 p.m., CNA B was assigned to Resident 1 on 6/12/26, CNA B stated she toileted Resident 1 at approximately 9:30 a.m. and took Resident 1 to the dining/activity room. CNA B stated this was the last time she saw Resident 1 before the fall. CNA B stated Resident 1 would stand up independently even though Resident 1 was unsteady. CNA B stated she was assigned nine residents on that shift. CNA B stated she was providing incontinence care to another resident at the time of the fall. CNA B stated an RNA informed her Resident 1 was on the floor. CNA B stated she believed Resident 1 fell because she had nine assigned residents. Review of the CNA room assignment sheet dated 6/12/26 indicated CNA B was assigned nine residents on the shift.During an interview with the Activity Assistant C (AA C) on 6/30/26 at 2:05 p.m., AA C stated she was in the dining room on 6/12/26. AA C stated Resident 1 was active, kept himself busy with activities, ate slowly, and could wheel himself. AA C stated staff redirected Resident 1 as needed. AA C stated she did not see Resident 1 leave the dining room and did not know what happened at the time of the fall.During an interview with the Restorative Nurse Assistant D (RNA D) on 6/30/26 at 2:15 p.m., RNA D stated Resident 1 comes to the dining room daily, required set-up assistance with meals, and could feed himself. RNA D stated Resident 1 usually finished eating late and was usually one of the last residents to leave the dining room. RNA D stated the last time he saw Resident 1 he was eating in the dining room. RNA D stated he did not see Resident 1 leave the dining room or see Resident 1 in the hallway before the fall.During an interview with the Licensed Vocational Nurse E (LVN E) on 6/30/26 at 3:00 p.m., LVN E stated he was the charge nurse assigned to Resident 1 on 6/12/26. LVN E stated he last saw Resident 1 around noon when giving medications. LVN E stated Resident 1 could not verbalize his needs and could wheel himself. LVN E stated he saw Resident 1 lying on the bathroom floor near the toilet. During a phone interview with RNA F on 7/2/26 at 11:16 a.m., RNA F stated Resident 1's lunch tray was late on 6/12/26 and that everyone else had finished eating except Resident 1. RNA F stated he was pushing other residents back to their rooms. RNA F stated AA C remained in the dining room while Resident 1 was eating. RNA F stated a CNA later told him Resident 1 was on the floor. RNA F stated he went to Room A and saw Resident 1 lying on the bathroom floor near the toilet.During a phone interview with CNA G on 7/2/26 at 2:16 p.m., CNA G stated she was walking in the hallway toward the dining/activity room when she passed Room A and saw a wheelchair outside the bathroom. CNA G stated she went inside to check and observed Resident 1 lying on the bathroom. floor. CNA G stated she immediately called the RNA. Review of the undated facility policy titled Falls - Clinical Protocol indicated .Treatment/Management .If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions,based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance) .