STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055203	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Village Care Center	1428 S. Marengo Ave. Alhambra, CA 91803

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 0602 Level of Harm - Potential for minimal harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. 28851 Based on interview and record review, the facility failed to log or take inventory of Resident 1's personal and current medications brought in by Resident 1. This failure had a potential for misappropriation of resident properties. Findings: A review of Resident 1's admission record indicated Resident 1 was admitted at the facility on 2/12/2021 had the following diagnoses: type 2 diabetes mellitus (high blood sugar) with unspecified complications, heart failure, muscle wasting, and legal blindness. During an interview on 9/5/2024 at 10:05 AM, the administrator (ADM) stated Resident 1 reported a theft of his medication Ozempic (an injectable medication used to help manage type 2 diabetes) on 8/22/2024. During an interview on 9/5/2024 at 10:10 AM, the director of nursing (DON) stated Resident 1 requested to personally pick up all of the resident's medications from an outside pharmacy since last year (unsure of exact date). During an interview on 9/5/2024 at 12 PM, Resident 1 stated he called the police to report a theft of his Ozempic on 8/22/2024 because there was a dose of Ozempic unaccounted for. Resident 1 stated he requested a dose of Ozempic around 7 PM on 8/21/2024 in the dining room. Resident 1 stated there should be 1 opened box with 1 dose left and 2 new unopened boxes in the personal medication refrigerator inside his room. Resident 1 stated License Vocational Nurse (LVN) 3 presented 2 new sealed unopened boxes and 2 extra needles, and the opened box that would have contained the Ozempic syringe pen with a remaining dose was missing. During an interview on 9/5/2024 at 12:45 PM, the DON stated personal medications brought in by the resident or family are considered resident's property and should have been inventoried and documented. During a concurrent interview on 9/5/2024 at 12:50 PM, the DON stated the facility did not keep a log or inventory of the medications that Resident 1 had brought in from September 2023 to 8/23/2024. (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 0602 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 9/5/2024 at 2:30 PM, Resident 1 stated he usually dropped off his medications to the LVN on duty after he picked up the medications from his outside pharmacy since September 2023. Resident 1 stated he kept track of his Ozempic medications because it is very expensive. A review of the facility's policy and procedures, Personal Property (dated 12/2008), indicated the resident's personal belongings shall be inventoried and documented, and as such items are replenished.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28851 Based on observation, interview, and record review, the facility: 1. Failed to have a process in place and include in their policy and procedure for Medications Brought to the Facility by the Resident/Family (dated April 2007) and Bedside storage of medications (dated September 2010) the handling and management of Resident 1's Ozempic (an injectable medication used to help manage type 2 diabetes mellitus [high blood sugar]) brought in by the Resident 1's family, being stored at bedside and administered by the facility's nursing staff. 2. Failed to ensure licensed nurse documented the injection site for 1 of 4 Ozempic injections (administered on 8/14/2024) that Resident 1 received on August 2024. 3. Failed to ensure two (2) expired medications and discontinued medications of discharged residents would be stored and discarded as per facility's policy. 4. Failed to document the temperature monitoring of a medication refrigerator located in the infection preventionist's office for 30 out of 62 days in July and August 2024. These deficient practices had the potentials for theft, medication errors, and/or negative affects to the medications that may be stored under undesirable condition. Findings: 1. During a review of Resident 1's admission record indicated Resident 1 was initially admitted to the facility on [DATE]. Resident 1 had the following diagnoses: type 2 diabetes mellitus (high blood sugar) with unspecified complications, heart failure, muscle wasting, legal blindness. During a review of Resident 1's physician order stated 9/22/2023 indicated May dispense all medication at [an outside retail pharmacy] per resident's request. During an interview on 9/5/2024 at 10:10 AM, the Director of Nursing (DON) stated Resident 1 is very alert, oriented, and can make decisions for himself. The DON stated Resident 1 requested to personally pick up all of his medications from an outside pharmacy since September 2023 (unsure of exact date). The DON stated Resident 1 is very alert and oriented. During an interview on 9/5/2024 at 11:40 AM, Registered Nurse (RN 1) stated Resident 1's medications is coming from the nearby retail pharmacy. RN 1 stated Resident 1 would give the medications to a licensed nurse at the nursing station. RN 1 stated the staff during the evening shift (3 PM - 11PM) would receive the medications from Resident 1 and RN 1 was not sure if the staff log/ documents the medications received. During an observation on 9/5/2024 at 11:46 AM at the nursing station on the second floor, RN 1 opened the north side medication cart and presented Resident 1's medication (except Ozempic) that were kept in the medication cart. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/5/2024 at 12:45 PM, the DON stated if medications were brought in by the resident and are active orders (medication not discontinued), the facility usually would not administer medications that were brought in by the resident. The DON stated the facility would order the medications from the facility's pharmacy, and then return the medications brought in by resident's to the family; if resident had no family, the facility would store those medications in the medication rooms and keep an inventory of the medications in the resident's chart. During an interview on 9/5/2024 at 12:48 PM, the DON confirmed the procedures aforementioned did not match the policy or was not included in the facility's policy for Medications Brought to the Facility by the Resident/Family and Bedside storage of medications. During a concurrent interview on 9/5/2024 at 12:50 PM, the DON stated the facility did not keep a log or inventory of the medications that Resident 1 had brought in from September 2023 to 8/23/2024. During a review of the facility's policy and procedures, Medications Brought to the Facility by the Resident/Family (dated 2007), did not include the procedures of the handling of medications brought in by the resident/ resident's family (Resident 1) that would be administered by the facility licensed nursing staff. During a review of the facility's policy and procedures, Bedside storage of medications (dated 9/2010) did not indicate procedures for storing non-self-administer medications at bedside. This policy also did not indicate the management of bedside medications that would require refrigeration. 2. During a review of Resident 1's physician order dated 12/4/2023 at 2 PM indicated to discontinue previous Ozempic order and start Ozempic 2 milligrams (mg, a unit to measure mass) inject subcutaneously (under the skin) every Wednesday for type 2 diabetes mellitus. During a review Resident 1's medication administration record (MAR) for August 2024, under Ozempic, indicated the administration on 8/14/2024 did not have a documentation of the injection site. During a concurrent interview and record review on 9/5/2024 at 11:30 AM, with Registered Nurse (RN)1, Resident 1's medication administration records for 8/2024 was reviewed. RN 1 stated the licensed vocational nurse (LVN) who administered the Ozempic dose on 8/14/2024 did not document the site of injection. RN 1 reviewed the nurses' note on 8/14/2024 and stated there was no documentation indicating the last injection site used for Resident 1's Ozempic administration. During a review of the facility's policy and procedures, Administering Medication (dated 4/2019), indicated . As required or indicated for a medication, the individual administering the medication records in the resident's medical record . the injection site . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation on 9/5/2024 at 4:59 PM at the Infection prevention nurse's office with the DON, there was a medication refrigerator. Inside this refrigerator, there were various vaccines, the DON stated there were two (2) insulin (medication to treat diabetes or high blood sugar) vials and 9 suppositories (a small, cone- or round-shaped medication delivery system that melts or dissolves inside the body to release its contents) labeled for 3 residents who were already discharged from the facility. The DON also confirmed there were 2 boxes of expired Levemir Flex (a trade name for a type of insulin used to treat diabetes) stored in this medication refrigerator. The DON stated expired medications (2 boxes of Levemir) and discontinued medication (2 insulins and 9 suppositories) should be stored in the designated area in the medication room for disposal. During a review of the facility's policy and procedures, Disposal of Medication dated 9/2010, indicated . Discontinued medications and/or medications left in the care center after a resident's discharge, . are identified and removed from current medication supply in a timely manner for disposition . The policy also indicated outdated medications, contaminated, or deteriorated medications shall be destroyed according to the policy. During a review of the facility's policy and procedure, Medication Storage dated 9/2010, indicated the nursing staff is responsible for proper rotation of bedside stock and removal of expired medications. 4. During an observation on 9/5/2024 at 4:59 PM at the Infection preventionist's office, there was a medication refrigerator. Inside this refrigerator, there were various vaccines and medications. During a review of the Medication Refrigerator (located inside the Infection preventionist's office) Temperature Log dated July to August 2024 indicated there were 30 days out of 62 possible days that were blank, without a temperature recording to indicate the temperature was within range. During a concurrent interview and record review on 9/5/2024 at 5:26 PM, the Medication Refrigerator Temperature Log located in the Infection preventionist's room, dated July to August 2024 was reviewed. The DON stated there were 30 days out of the 62 possible days that it was left blank meaning the temperature check was not done. The DON also stated, staff should check and document the refrigerator temperature daily to ensure the vaccines and medications that are kept in the refrigerator are stored in accordance with the temperature requirement because if not, it loses its effectivity and or can expire quickly. The DON also stated, she could not find refrigerator temperature daily log for 9/2024. During a review of the facility's policy and procedures, Medication Storage, dated 9/2010, indicated . medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) . are kept in a refrigerator with a thermometer to allow temperature monitoring .