

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055737	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  Sunny Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  12200 LA Mirada Blvd. LA Mirada, CA 90638	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46505</p> <p>Based on observation, interview and record review, the facility failed to ensure Nursing staff completed the following for one of six sampled resident's (Resident 1):</p> <ol style="list-style-type: none"> <li>1 Reconciled (process of reviewing resident medications to identify the most accurate list of all medications and resolve any discrepancies) the medication list correctly upon admission to the facility.</li> <li>2. Administered Sucralfate (a drug used to decrease bleeding associated with radiation-induced proctitis) twice a day as ordered by the physician.</li> <li>3. Accurately documented the administration of Sucralfate in the medical record.</li> </ol> <p>These deficient practices had the potential to result in medication errors, worsening of symptoms and condition, which could lead to hospitalization and complications for Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including malignant neoplasm (disease when abnormal cells grow out of control) of the prostate (a gland in the male reproductive system) and hemorrhage (bleeding) of anus and rectum. The Admission Record indicated Resident 1 was self-responsible.</p> <p>During a review of Resident 1's General Acute Care Hospital (GACH) Discharge Medication List dated 10/3/2024, the Medication List indicated Resident 1 was ordered Sucralfate 1 gram ([gm] unit of measurement, used for medication dosage) 2 tablets in 20 milliliters of water to make a slurry mixture, then administer as rectal enema (a procedure that involves injecting a liquid into the rectum through the anus) twice daily for 4 weeks. The Medication List indicated Resident 1 received last dose of the medication on 10/3/2024 at 8:23 a.m.</p> <p>During a review of Resident 1's Progress Notes Clinical admitted d 10/3/2024, the Notes indicated Resident 1 was Alert and Oriented, able to communicate with clear speech and able to understand. The Notes indicated Resident 1 had constipation and rectal bleeding with clots.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's History and Physical (H&amp;P), dated 10/4/2024, the H&amp;P indicated Resident 1 had a history of radiation proctitis (inflammation or swelling in the lining of the rectum after exposure to radiation therapy [cancer treatment that uses high doses of radiation to kill cancer cells]).</p> <p>During a review of Resident 1's Physician's Order dated 10/3/2024, the Order indicated to Administer Sucralfate) one gm two tablets two times a day for constipation.</p> <p>During a review of Resident 1's Physician's Order dated 10/7/2024 at 2:37 a.m., the Order indicated Sucralfate as indicated on 10/3/2024 was clarified was discontinued. The Order indicated the order was changed to administer Sucralfate one gm, 2 tablets rectally two times a day for radiation proctitis for 4 weeks. The Order indicated to dissolve 2 tablets in 20 milliliters of water to make a slurry mixture, then administer as a rectal enema.</p> <p>During an interview on 10/7/2024 at 1:55 p.m. with Resident 1, Resident 1 stated he had prostate cancer and had radiation proctitis which caused rectal bleeding. Resident 1 stated he was supposed to receive sucralfate enemas however the nurses had not administered the enemas for about one week. Resident stated, the nurse (unnamed) finally gave the medication to him last night (on 10/6/2024). Resident 1 stated he lost a lot of blood in the diaper during the time the nurse did not give him the enema.</p> <p>During a review of Resident 1's Medication Administration Record (MAR), dated 10/2024, the MAR indicated Resident 1 had an order to Administer Sucralfate one gm. 2 tablets rectally two times a day for constipation with a start of 10/4/2024 at 6:00 a.m. and discontinued on 10/7/2024 at 2:37 a.m. The MAR indicated the administration documentation was blank on 10/4/2024 at 6:00 a.m. and the administration documentation had a chart code 2 (hold [not given]) documented for 10/5/2024 at 2:00 p.m. and 10/6/2024 at 2:00 p.m. The MAR also indicated Resident 1 had an order to Administer Sucralfate one gm. 2 tablets rectally two times a day for radiation proctitis for 4 weeks with a start of 10/7/2024 at 6:00 a.m. The MAR indicated a total of 6 doses were administered to Resident between 10/4/2024 through 10/8/2024.</p> <p>During a review of Resident 1's Progress Notes dated 10/5/2024 at 2:39 p.m., the Notes indicated Licensed Vocational Nurse (LVN) 4 held Resident 1's Sucralfate due to bleeding.</p> <p>During a review of Resident 1's Progress Notes dated 10/6/2024 at 2:11 p.m., the Notes indicated Licensed Practical Nurse (LPN) 1 held Resident 1's Sucralfate due to rectal bleeding.</p> <p>During a concurrent observation and interview on 10/8/2024 at 2 p.m., with Licensed Vocational Nurse (LVN 1), Resident 1's medication bubble pack (medication packaging within small, clear plastic bubbles or blisters) had four blisters empty. LVN 1 stated Resident 1's Sucralfate was filled (by pharmacy) on 10/3/2024 and four doses had been administered to Resident 1 (not 6).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation, record review and interview on 10/8/2024 at 3:02 p.m. with the Director of Nursing (DON), The DON stated, Resident 1's Sucralfate was ordered with the incorrect indication on admission. The DON stated the purpose of the Sucralfate was for proctitis with bleeding and the order was entered incorrectly. The DON stated, Sucralfate was held on 10/5/2024 at 2:00 p.m. and on 10/6/2024 at 2:00 p.m. for bleeding however should have been given as ordered. The DON also stated according to the bubble pack and MAR documentation, there was a discrepancy of two doses, and it meant the nurse documented the medication was given when it was not. The DON stated the documentation was not correct and nurses did not follow the doctor's orders which could potentially cause the resident's condition to decline.</p> <p>During a review of the facility Policy and Procedure (P&amp;P) titled, Medication Orders dated 12/19/2022, the P&amp;P indicated written transfer orders (sent with a resident by a hospital or other health care facility) are implemented without further validation, if it is signed and dated by the residents current attending physician, unless the order is unclear, incomplete, or the date signed is different from the date of admission. The P&amp;P indicated, if the order is unsigned, signed by another physician, or the date is other than the date of admission, the receiving nurse should verify the order with the current attending physician before medications are administered. The P&amp;P indicated the nurse should document verification on the admission order record, by entering the time, date, and signature.</p> <p>During a review of the facility's P&amp;P titled, Medication Administration, dated 12/19/2022, the P&amp;P indicated, medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. The P&amp;P indicated to sign the MAR after medication is administered and to correct any discrepancies and report to nurse manager.</p> <p>During a review of the facility's P&amp;P titled, Documentation in Medical Record, dated 12/19/2022, the P&amp;P indicated documentation should be accurate, relevant, and complete.</p>		