

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 10/31/2024
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on observation, interview, and record review, the facility failed to ensure the resident's responsible party (RP) was informed in advance, of the risks and benefits of the use of bedrails (adjustable metal or rigid plastic bars that attach to the bed) for one of eight sampled residents (Resident 331).</p> <p>This deficient practice resulted in the violation of Resident 331's RP's right to make an informed decision regarding the use of bedrails.</p> <p>Findings:</p> <p>During a review of Resident 331's Admission Record (Face Sheet), the admission record indicated Resident 331 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 131's diagnoses included sepsis (a life-threatening blood infection), dementia (a progressive state of decline in mental abilities), and chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 331's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 8/25/2024, the MDS indicated Resident 331's cognition (process of thinking) was severely impaired. The MDS indicated Resident 331 was dependent on staff for assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>During a review of Resident 331's History and Physical Examination (H&P), dated 10/26/2024, the H&P indicated Resident 331 did not have the capacity to understand and make decisions.</p> <p>During an observation on 10/28/2024 at 9:45 a.m. and on 10/29/2024 at 8:36 a.m., in Resident 331's room, Resident 331 was observed lying in bed and with bilateral (both sides) bedrails up.</p> <p>During an interview on 10/31/2024 at 8:19 a.m., with Registered Nurse (RN) 1, RN 1 stated bed rails were utilized only if they were beneficial for the resident such as a mobility aid. RN 1 stated prior to placing bedrails, the physician would give the order for bedrails and was responsible for explaining to the resident and/or their RP regarding the risks and benefits of using bedrails. RN 1 stated the licensed nurse would then verify from the resident and/or the RP that all their questions were answered, and they were fully informed of the use of bedrails. RN 1 stated they could not apply the bedrails unless the resident and/or RP consented to its use.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055737
		If continuation sheet Page 1 of 68

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 10/31/2024
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/31/2024 at 8:23 a.m., with RN 1, in Resident 331's room, Resident 331 was observed in bed and with bilateral bedrails. RN 1 stated Resident 331 was unable to move on his own and he should not have bedrails.</p> <p>During a concurrent interview and record review on 10/31/2024 at 8:24 a.m., with RN 1, Resident 331's Orders were reviewed. The Orders did not indicate that Resident 331's physician ordered the use of bedrails. RN 1 stated without a physician's order for bedrails, the bedrails should not have been placed for Resident 331.</p> <p>During a concurrent interview and record review on 10/31/2024 at 8:36 a.m., with RN 1, Resident 331's Medical Record was reviewed. The Medical Record did not indicate that Resident 331's responsible party (RP 2) consented to the use of bedrails. RN 1 stated there was no consent given by RP 2 nor any other documentation that informed consent was verified prior to placing the bedrails for Resident 331. RN 1 stated it was important to verify RP 2 was informed of the risks and benefits so they could make an informed decision regarding the use of bedrails. RN 2 stated without consent from RP 2, there was no definitive way to say RP 2 understood the reason for the bedrails and the risks that were associated with them RN 2 stated RP 2 would not be able to make a completely informed decision regarding Resident 331's care.</p> <p>During an interview on 10/31/2024 at 11:47 a.m., with the Director of Nursing (DON), the DON stated prior to utilizing bedrails for a resident, an assessment for the need and risk had to be completed. The DON stated the licensed nurse would then verify with the resident and/or their RP that they were informed of the risks associated with the bedrail usage. The DON stated because RP 2 was not informed of the use of bedrails and did not consent to its use; they would not be fully aware of the care and treatment that Resident 331 was receiving.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Proper Use of Bed Rails, revised 12/19/2022, the P&P indicated informed consent from the resident, or their RP must be obtained prior to the installation and use of bed rails.</p>		

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 10/31/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of eight sampled resident's (Resident 5) call light was within reach.</p> <p>This deficient practice prevented Resident 5 from communicating with staff and had the potential to delay appropriate care, treatment, and services.</p> <p>Findings:</p> <p>During a review of Resident 5's Admission Record, dated 10/31/2024, the admission record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included muscle weakness, anxiety disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed), dementia (a progressive state of decline in mental abilities), functional quadriplegia (paralysis from the neck down, including legs, and arms without injury to the brain or spinal cord), contracture of right hand (a stiffening/shortening at any joint, that reduces the joint's range of motion), lack of coordination, and anemia (a condition where the body does not have enough healthy red blood cells).</p> <p>During a review of Resident 5's Social Service Assessment, dated 12/22/2022, the social services assessment indicated Resident 5 had no capacity to make decisions.</p> <p>During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/17/2024, the MDS indicated Resident 5's cognition (ability to think, remember, and reason) was severely impaired. The MDS indicated Resident 5 had some difficulty communicating words and thoughts but could comprehend most conversation. The MDS indicated Resident 5 was dependent and required the assistance of two or more helpers for eating, toileting, bathing, and personal hygiene. The MDS indicated Resident 5 had impairments on both sides of the lower extremities and to one side of the upper extremity.</p> <p>During a review of Resident 5's care plan with a focus of Resident at risk for falls due to impaired cognitive and thought processes, initiated on 1/1/2019 and last revised on 6/29/2024, the care plan indicated Resident 5 was at risk for falls related to major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), glaucoma (an eye disease that gradually worsens vision), and psychoactive (alters brain function) and antihypertensive (lowers high blood pressure) drug use. The care plan interventions indicated to anticipate and meet the resident's needs and to have a call light within reach.</p> <p>During a review of Resident 5's care plan with a focus of Activities of Daily Living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) self-care performance deficit, initiated on 1/22/2019 and last revised on 6/29/2024, the care plan indicated Resident 5 would maintain current level of function without complication. The care plan interventions indicated Resident 5 would be encouraged to use the bell to call for assistance.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/28/2024 at 12:45 p.m., with Resident 5, in Resident 5's room, observed Resident 5 lying in bed with padded call light positioned above the left side of the resident's head. Resident 5 stated she was cold and needed to be covered up. Resident 5 linens were lying on the floor next to her bed. Resident 5 was asked if she was able to use her call light to notify a nurse. Resident 5 yelled No! and demanded that she be covered up and pulled up in bed. Resident 5 began yelling out, I am cold! Cover me up!. Resident 5 repeatedly yelled out that she was cold and needed to be covered up pulled up in bed.</p> <p>During an interview on 10/31/2024 at 12:00 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated it was important for Resident 5 to have a call light within reach because Resident 5 had a tendency to become frustrated, angry and lash out when her needs were not met. LVN 5 stated it would be difficult to calm Resident 5 down once she became angry and frustrated.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Fall Prevention Program, revised 12/28/2023, the P&P indicated, The nurse and/or interdisciplinary team will initiate interventions on the resident's care plan, in accordance with the resident's level of risk. The P&P indicated fall interventions included a clear pathway to the bathroom, call light and frequently used items are within reach and adequate lighting.</p>		

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 10/31/2024
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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900</p> <p>Based on observation, interview and record review, the facility failed to remove the identifiable health information (any information that could be used to identify the individual, such as the full name, date of birth, etc.) on the intravenous (IV, within the vein) medication bag prior to disposition in the trash can for one of nine sampled residents (Resident 30).</p> <p>This deficient practice had the potential to result in unauthorized disclosure of Resident 30's personal information to unauthorized users.</p> <p>Findings:</p> <p>During an observation on 10/28/2024 at 9:33 a.m., in Resident 30's room, Resident 30's empty IV medication bag with identifiable health information was found in the trash can with no lid.</p> <p>During a review of Resident 30's Admission Record, the admission record indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), sepsis (a life-threatening blood infection), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 30's History and Physical (H&P), dated 9/12/2024, the H&P indicated Resident 30 did not have the capacity to make medical or financial decisions.</p> <p>During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/10/2024, the MDS indicated Resident 30's cognitive (the ability to think and process information) skills for daily decision making was severely impaired.</p> <p>During a review of Resident 30's Medication Administration Record (MAR) for October 2024, the MAR indicated Resident 30 received ertapenem (antibiotic used for the treatment of moderate to severe infections) IV on 10/28/2024 at 8:31 a.m.</p> <p>During an interview on 10/30/2024 at 10:01 a.m. with Registered Nurse (RN) 1, RN 1 stated only RNs could manage IV therapy and had to use a black sharpie to blacken the resident's information on the IV medication bag before disposal. RN 1 stated it was not acceptable to see the IV medication bag with identifiable health information in Resident 30's trash can. RN 1 stated it was important to protect Resident 30's dignity and confidentiality. RN 1 stated the potential risk was a Health Insurance Portability and Accountability Act (HIPPA, a federal law that protects patients' medical records and other personal health information) violation. RN 1 stated all staff were responsible to protect the resident's confidentiality.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Confidentiality of personal and medical records, revised on 12/19/2022, the P&P indicated the facility honored the resident's right to a secure and confidential personal and medical record.</p>		

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 10/31/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on observation, interview, and record review, the facility failed to provide a homelike environment for three of eight sampled residents (Residents 46, 94, and 100) who shared a room and had old, yellow stains on the ceiling and an unfinished painted wall of their room.</p> <p>This deficient practice resulted in Residents 46, 94, and 100 being unhappy with the quality of their living space.</p> <p>Findings:</p> <p>During an observation on 10/28/2024 at 1:30 p.m., inside Residents 46, 94, and 100's room, a yellow stain was observed sprawled along the ceiling near the door. The wall near the door was observed with an uneven surface and an uneven pain color.</p> <p>a. During a review of Resident 46's Admission Record (Face Sheet), indicated Resident 46 was admitted to the facility on [DATE]. Resident 46's diagnoses included chronic kidney disease (a long-term condition where the kidneys are damaged and can't filter blood properly), depression (mood disorder that causes a persistent feeling of sadness and loss of interest in life), and type two (2) diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 46's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 9/10/2024, the MDS indicated Resident 46's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 46 was dependent on staff with oral hygiene, toileting, bathing, and dressing.</p> <p>During a review of Resident 46's History and Physical (H&P), dated 10/17/2024, the H&P indicated Resident 46 had the capacity to understand and make decisions.</p> <p>During an interview on 10/28/2024 at 8:36 a.m., with Resident 46, Resident 46 stated the water stain on the ceiling had been there for a while and she did not remember when the stain first appeared. Resident 46 stated she was unsure what the facility was doing to get rid of the yellow stain on the ceiling and the uneven paint on the wall. Resident 46 stated, It is an eye sore.</p> <p>b. During a review of Resident 100's Admission Record (Face Sheet), indicated Resident 100 was admitted to the facility on [DATE]. Resident 100's diagnoses included type 2 diabetes mellitus, dementia (a progressive state of decline in mental abilities), and depression.</p> <p>During a review of Resident 100's MDS, dated [DATE], the MDS indicated Resident 100's cognition was severely impaired. The MDS indicated Resident 100 required supervision with eating and personal hygiene and was dependent on staff with toileting, bathing, and dressing.</p> <p>During a review of Resident 100's H&P, dated 10/17/2024, the H&P indicated Resident 100 was alert (actively aware of their surroundings) and oriented to herself only (has a sense of who they are and able to identify themselves).</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/28/2024 at 8:36 a.m., with Resident 100, Resident 100 stated the water marks had been on the ceiling for the last six months. Resident 100 stated the ceiling and wall were very ugly and I do not like looking at it.</p> <p>c. During a review of Resident 94's Admission Record (Face Sheet), indicated Resident 94 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 94's diagnoses included dementia, depression, and hyperlipidemia (an abnormally high concentration of fat particles in the blood).</p> <p>During a review of Resident 94's MDS, dated [DATE], the MDS indicated Resident 94's cognition was severely impaired. The MDS indicated Resident 94 requires supervision with eating, oral hygiene, and personal hygiene and was dependent on staff with showering and dressing.</p> <p>During an interview on 10/30/2024 at 1:58 p.m., with Responsible Party (RP) 1, RP 1 stated the water mark on the ceiling had been there for about six months and the facility fixed the damage, but did not finish painting over the stain on the ceiling and wall. RP 1 stated the water marks and unpainted wall was very ugly and Resident 94, Resident 46, and Resident 100 should not have to look at that every day.</p> <p>During an interview on 10/30/2024 at 1:52 p.m., with the Regional Maintenance Director (RMD), the RMD stated maintenance staff were to check the rooms, including the walls, floors, beds, ceiling, tables, and curtains. The RMD stated maintenance staff were to check for any water stains or damage to any part of the room or furniture. The RMD stated once anything was acknowledged, staff would have to gather the supplies to fix the damage or stains. The RMD stated in Residents 46, 94, and 100's room, there was a previous water leak that was repaired; however, the previous Maintenance Director did not paint over the staining. The RMD stated repairing damages was important to ensure the residents were taken care of because the facility was their home and any repairs should be made in a timely fashion.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment, revised 12/19/2022, the P&P indicated, The facility will provide a safe, clean, and comfortable and homelike environment.</p>		

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 10/31/2024
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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>49900</p> <p>Based on interview and record review, the facility failed to conduct background criminal checks for four of four randomly selected employees prior to hire and upon completion of orientation (a process that introduced new hires to their job, company, and coworkers) in accordance with the facility's policy.</p> <p>This deficient practice had the potential to place residents at risk for abuse which could lead to serious harm and/or injuries.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 10/31/2024 at 3:46 p.m. with the Director of Staff Development (DSD), Registered Nurse (RN) 1's employee file was reviewed. The DSD stated RN 1 was hired on 9/9/2003 and there was no background criminal check upon hire. The DSD stated the earliest background criminal check on file for RN 1 was done in 6/2007.</p> <p>During a concurrent interview and record review on 10/31/2024 at 3:50 p.m. with the DSD, Licensed Vocational Nurse (LVN) 4's employee file was reviewed. The DSD stated LVN 4 was hired on 10/25/2023 and the background criminal check was done on 11/3/2023. The DSD stated LVN 4's orientation was completed on 10/25/2024.</p> <p>During a concurrent interview and record review on 10/31/2024 at 3:54 p.m. with the DSD, LVN 1's employee file was reviewed. The DSD stated LVN 1 was hired on 10/16/2024 and there was no background criminal check upon hire. The DSD stated LVN 1's orientation was completed on 10/16/2023.</p> <p>During a concurrent interview and record review on 10/31/2024 at 3:58 p.m. with the DSD, LVN 2's employee file was reviewed. The DSD stated LVN 2 was hired on 8/13/2024 and there was no background criminal check upon hire. The DSD stated LVN 2's orientation was completed on 8/13/2024. The DSD stated background checks should be done prior to hiring an employee because the facility needed to make sure not to hire anyone with a criminal background.</p> <p>During a review of the facility's policy and procedure (P&P) titled Pre-employment screening, revised on 1/25/2024, the P&P indicated Criminal conviction record checks are conducted on all personnel making application for employment with this company per state and federal regulation and or at the discretion of the employer. The above verifications shall only be completed after a contingent offer of employment has been made, but before the employee concluded their orientation.</p>		

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 10/31/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on observation, interview, and record review, the facility failed to develop a person-centered care plan (document that helps nurses and other team care members organize aspects of resident care) with interventions (actions a nurse takes to implement a care plan, intend to improve the resident's comfort and health) for two of 16 sampled residents' (Residents 66 and 331) by failing to:</p> <ol style="list-style-type: none"> 1. Develop a care plan for Resident 331's use of bedrails. 2. Develop a care plan for Resident 66 whose predominant language was Korean. <p>These failures had the potential to negatively affect Residents 331 and 66's physical and mental, and psychosocial and potentially delay delivery of necessary care and services.</p> <p>Findings:</p> <p>a. During a review of Resident 331's Admission Record (Face Sheet), indicated Resident 331 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that include but not limited to sepsis (a life-threatening blood infection), dementia (a progressive state of decline in mental abilities), and chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 331's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 8/25/2024, the MDS indicated Resident 331's cognition (process of thinking) was severely impaired. The MDS indicated Resident 331 was dependent on staff with assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>During a review of Resident 331's History and Physical Examination (H&P), dated 10/26/2024, the H&P indicated Resident 331 did not have the capacity to understand and make decisions.</p> <p>During an observation on 10/28/2024 at 9:45 a.m. and on 10/29/2024 at 8:36 a.m., in Resident 331's room, Resident 331 was observed lying in bed with bilateral (both sides) bedrails up.</p> <p>During a concurrent interview and record review on 10/31/2024 at 8:44 a.m., with Registered Nurse (RN) 1, Resident 331's Care Plans were reviewed. The Care Plans did not indicate Resident 331 had bedrails in place. RN 1 stated Resident 331 had bedrails in place, thus, the resident should have had a care plan to indicate the problem, the goal, and the interventions on how to properly care for Resident 331. RN 1 stated one of the purposes of a care plan was to reevaluate the problem that the resident had and if the goals were met. RN 1 stated care plans were made to evaluate if the interventions were effective in providing the necessary care to the resident. RN 1 stated due to Resident 331's use of bedrails, interventions that should have been developed and implemented to include monitoring Resident 331's skin, risk for entrapment, and overall use of the bedrails. RN 1 stated without a care plan that addressed Resident 331's use of bedrails, the resident was at risk of not receiving the proper monitoring and supervision to prevent injury and other necessary care.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/2024 at 11:47 a.m., with the Director of Nursing (DON), the DON stated developing a care plan based on a resident's use of bedrails was essential to ensure the resident received the necessary care. The DON stated they should follow the interventions set out in the care plan which would include monitoring the resident for any injury or negative effects of the use of bed rails.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Proper Use of Bed Rails, revised 12/19/2022, the P&P indicated, The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards and the resident's choices. This should be evidenced in the resident's records, including their care plan.</p> <p>48131</p> <p>b. During a review of Resident 66's Record of Admission, dated 10/31/2024, the admissions record indicated Resident 66 was admitted to the facility on [DATE]. Resident 66's diagnoses included fracture of the right femur (a break in the bone of the thigh), dysphagia (difficulty swallowing), difficulty walking, end stage renal disease (ESRD - irreversible kidney failure), sepsis (a life-threatening blood infection), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), a history of falling.</p> <p>During a review of Resident 66's H&P, dated 9/16/2024, the H&P indicated Resident 66's had a language barrier because her primary language was Korean.</p> <p>During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had moderately impaired cognitive skills. The MDS also indicted Resident 66 had difficulty communicating some words or finishing thoughts and understands but missed some parts or intent of verbal messages. The MDS indicated Resident 66 required setup or clean-up assistance for eating, dependent with toileting and bathing, and required moderate assistance with personal hygiene.</p> <p>During a review of Resident 66's care plans on 10/30/2024, no care plan was initiated regarding Resident 66's language barrier.</p> <p>During a concurrent observation and interview on 10/28/2024 at 1:07 p.m. with Resident 66, in Resident 66's room, there was no communication board observed. Resident 66 stated she spoke Korean and the staff did not always understand what she was saying. Resident stated she had never been given a communication board.</p> <p>During a concurrent interview and record review on 10/31/2024 at 11:46 a.m., with Licensed Vocational Nurse (LVN) 5, Resident 66's care plans were reviewed. LVN 5 stated she was unable to locate a care plan regarding Resident 66's communication barriers. LVN 5 stated if Resident 66's primary language was Korean, Resident 66 should have had a care plan initiated with interventions. LVN 5 stated a communication barriers care plan was important so that nursing staff could follow Resident 66's plan of care and know how to care for a resident that spoke a language other than English.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/2024 at 12:43 p.m., with Registered Nurse (RN) 1, RN 1 stated the RN supervisor present at the time Resident 66 was admitted to the facility was responsible for completing an assessment to determine if a language device was required at Resident 66's bedside. RN 1 stated that a stand-up meeting was done the following day to discuss the resident and a care plan should have been initiated at that time. RN 1 stated the activities department and the MDS nurse should have assessed Resident 66 to find out her primary language.</p> <p>During a review of the facility's P&P titled, Effective Communication, revised 7/17/2023, the P&P indicated, It is the policy of this facility to accommodate needs when communicating with residents who have difficulties with communications to promote dignity, understanding, and safety. The P&P indicated effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand. The P&P indicated that staff would communicate with the resident, using techniques identified in their plan of care, and in accordance with his/her established routine for communication such as using communications boards or writing materials.</p> <p>During a review of the facility's P&P titled, Comprehensive Care Plans, dated 12/19/2022, the P&P indicated, It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the resident's comprehensive assessment.</p>		

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 10/31/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009</p> <p>Based on interview and record review, the facility failed to meet professional standards of quality of care for three out of 16 sampled residents (Resident 14, 30, and 49) when the following occurred:</p> <ol style="list-style-type: none"> Licensed nurses failed to follow the physician's order for bilevel positive airway pressure ([BIPAP], noninvasive ventilation mask that helps a person breathe, a treatment to provide oxygen and get rid of carbon dioxide) therapy for Resident 14. Licensed nurses falsified on the Medication Administration Record (MAR) that BIPAP application was carried out as ordered for Resident 14. Licensed nurses failed to provide medications, treatments, and monitoring as ordered on multiple shifts for Residents 30 and 49. <p>These deficient practices could have potentially led to a negative respiratory outcome and oxygen deprivation for Resident 14 during her sleep and delayed necessary care and treatment for Residents 30 and 49.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 14's Admission Record, the admission record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included obstructive sleep apnea (Intermittent airflow blockage during sleep) and chronic obstructive pulmonary disease ([COPD] group of chronic lung diseases that block airflow and make it harder to breathe air out of the lungs). <p>During a review of Resident 14's History and Physical (H&P) dated 9/15/2024, the H&P indicated Resident 14 had the mental capacity to make medical decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/14/2024, the MDS indicated Resident 14's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 14 required moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. The MDS indicated Resident 14 was dependent on staff for dressing, toileting hygiene and putting on and taking off footwear.</p> <p>During a review of Resident 14's Order Summary Report dated 9/11/2024, the order summary report indicated Resident 14 had an order for BIPAP machine at bedtime for COPD/obstructive sleep apnea.</p> <p>During a review of Resident 14's Medication Administration Record (MAR), for the month of October 2024, the MAR indicated Resident 14 used her BIPAP machine on 10/5/2024 - 10/11/2024, 10/13/2024, 10/14/2024, 10/16/2024 - 10/18/2024, 10/20/2024 - 10/23/2024, and 10/25/2024 - 10/28/2024.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/28/2024 at 2:55 p.m. with Resident 14, in Resident 14's room, Resident 14 stated she knew she had an order to use a BIPAP machine every night but the nurses did not provide the BIPAP machine to her. Resident 14 stated the nurses told her they did not provide her the BIPAP machine because they did not know how to use the BIPAP machine. Resident 14 stated she wanted to use the BIPAP machine because she knew she needed it during her sleep but the nurses refused to help her.</p> <p>During an interview on 10/30/2024 at 10:57 a.m. with Resident 14, Resident 14 stated the nurses did not to use the BIPAP machine last night (10/29/2024). Resident 14 stated she was worried for herself during her sleep because she had sleep apnea and needed the BIPAP machine.</p> <p>During an interview on 10/30/2024 at 4:02 p.m. with Licensed vocational Nurse (LVN 8), LVN 8 stated he had never used Resident 14's BIPAP machine. LVN 8 stated he never put the BIPAP machine on Resident 14. LVN 4 stated he knew Resident 14 had an order for the BIPAP machine, but he never put it on Resident 14. LVN 8 stated he documented that Resident 14 used her BIPAP machine, but she did not use it. LVN 8 stated he documented Resident 14 used her BIPAP machine when she did not because he was in a hurry and because he was busy. LVN 8 stated it was wrong to document Resident 14 received the BIPAP machine when she did not because it was a lie. LVN 8 stated it was important for Resident 14 to use her BIPAP machine because she needed it.</p> <p>During an interview on 10/30/2024 at 4:17 p.m. with LVN 9, LVN 9 stated Resident 14 needed the BIPAP machine because Resident 14 had sleep apnea and needed that extra oxygen during her sleep. LVN 9 stated she had not provided the BIPAP machine to Resident 14 because it had a missing piece. LVN 9 stated she did not inform anyone that there was a missing piece, and she did not notify Resident 14's physician that the resident did not use her BIPAP machine. LVN 9 stated she had never put BIPAP machine on Resident 14 but documented that she did. LVN 9 stated she should not have documented Resident 14 used the BIPAP machine because it was inaccurate.</p> <p>During an interview on 10/31/2024 at 12:40 p.m. with Registered Nurse (RN 1), RN 1 stated residents with respiratory issues while sleeping need a BIPAP machine while sleeping. RN 1 stated Resident 14 could potentially go to sleep and would not be able to breath and would have shortness of breath if the BIPAP machine was not used. RN 1 stated nurses should not document Resident 14 used the BIPAP machine when she did not use it because that was falsification. RN 1 stated when nurses did not provide the BIPAP machine to Resident 14, it was not following the physician's order.</p> <p>49900</p> <p>2. During a review of Resident 30's Admission Record, the admission record indicated Resident 30 was admitted to the facility on [DATE]. Resident 30's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), sepsis (a life-threatening blood infection), hyperlipidemia (high levels of fats in the blood), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 30's H&P, dated 9/12/2024, the H&P indicated Resident 30 did not have the capacity to make medical or financial decisions.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 30 was dependent on staff for toileting hygiene, showering, lower body dressing, putting on and taking off footwear, chair/bed-to-chair transfer and toilet transfer.</p> <p>During a review of Resident 30's Order Summary Report, as of 10/29/2024, the report indicated the followings orders:</p> <ul style="list-style-type: none"> a. Evaluate pain every shift, dated 6/10/2023. b. Monitor temperature and oxygen saturation (percentage of oxygen circulating in the blood) every shift, dated 6/10/2023. c. Monitor for level of pain every shift, dated 6/12/2023. d. Administer melatonin (sleep aid) at bedtime, dated 11/1/2023. e. Administer health shake (a blended beverage that was intended to be healthy and nutritious) two times a day for supplement, dated 1/17/2024. f. Check blood sugar and administer insulin Aspart (medication to control blood sugar) according to the blood sugar reading at bedtime for DM, dated 1/15/2024. g. Monitor risk of dehydration, encourage fluid, and ensure water pitcher beside bed every shift, dated 3/12/2024. h. Monitor for hours of sleep every shift, dated 6/14/2024. i. Administer remeron (medication to treat depression [a constant feeling of sadness and loss of interest]) at bedtime for circadian rhythm (the 24-hour internal clock in our brain that regulated cycles of alertness and sleepiness by responding to light changes in our environment), dated 6/29/2024. j. Monitor vital sign every shift, dated 7/9/2024. k. Administer atorvastatin (medication to lower fats levels in body) at bedtime for hyperlipidemia, dated 7/25/2024. l. Encourage oral hydration every shift, dated 10/12/2024. <p>During a review of Resident 30's MAR, for the month of October 2024, the MAR indicated no documentation for the following orders on the following dates:</p> <ul style="list-style-type: none"> a. Evaluate pain every shift on 10/21/2024 3 p.m. to 11 p.m. (evening shift), 10/26/2024 evening shift, 10/27/2024 evening shift, and 10/29/2024 7 a.m. to 3 p.m. (morning) shift. b. Monitor temperature and oxygen saturation every shift on 10/21/2024 evening shift, 10/26/2024 evening shift, 10/27/2024 evening shift, and 10/29/2024 morning shift. <p>(continued on next page)</p>		

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 10/31/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. Monitor level of pain every shift on 10/21/2024 evening shift, 10/26/2024 evening shift, 10/27/2024 evening shift, and 10/29/2024 morning shift.</p> <p>d. Administer melatonin at bedtime on 10/27/2024 at 9 p.m.</p> <p>e. Administer health shake twice a day on 10/27/2024 at 8 p.m.</p> <p>f. Check blood sugar and administer insulin Aspart according to the blood sugar reading at bedtime on 10/27/2024 at 9 p.m.</p> <p>g. Monitor risk of dehydration, encourage fluid, and ensure water pitcher beside bed every shift on 10/21/2024 evening shift, 10/26/2024 evening shift, 10/27/2024 evening shift, and 10/29/2024 morning shift.</p> <p>h. Monitor for hours of sleep every shift on 10/21/2024 evening shift, 10/26/2024 evening shift, 10/27/2024 evening shift, and 10/29/2024 morning shift.</p> <p>i. Administer atorvastatin at bedtime on 10/27/2024 at 9 p.m.</p> <p>j. Monitor vital signs every shift on 10/21/2024 evening shift, 10/26/2024 evening shift, 10/27/2024 evening shift, and 10/29/2024 morning shift.</p> <p>k. Administer Remeron at bedtime on 10/27/2024 at 9 p.m.</p> <p>l. Encourage oral hydration every shift on 10/21/2024 evening shift, 10/26/2024 evening shift, 10/27/2024 evening shift, and 10/29/2024 morning shift.</p> <p>During a concurrent interview and record review on 10/31/2024 at 10:38 a.m. with RN 1, Resident 30's MAR, for the month of October 2024, was reviewed. The MAR indicated there was no documentation indicating multiple orders on multiples shifts were carried out. RN 1 stated no documentation on the MAR meant it was not done. RN 1 stated the charge nurse was responsible for completing the MAR and needed to document after administering medication. RN 1 stated if Resident 30 refused a medication, the charge nurse also needed to document on the MAR. RN 1 stated the risk of not administering atorvastatin would affect Resident 30's lipid (fat) level and health which leads to high cholesterol, high heart rate, and possible stroke (damaged brain tissue). RN 1 stated no documentation on melatonin meant it was not given to Resident 30, and the risk was that Resident 30 would not have enough sleep and might become restless and uncomfortable. RN 1 stated not administering Remeron meant there was no consistency and Resident 30 would become sad. RN 1 stated missing monitoring meant no consistency in care, and it could possibly delay necessary care. RN 1 stated missing blood sugar checks or not monitoring blood sugar as ordered could lead to low or high blood sugar levels, and Resident 30 would be at risk for signs and symptoms (s/s) of low or high blood sugar levels, such as weakness, sleepiness, irritability, and altered mental status. RN 1 stated it was important to follow the physician's orders and document on the MAR.</p> <p>3. During a review of Resident 49's Admission Record, the record indicated Resident 49 was admitted to the facility on [DATE]. Resident 49's diagnoses included DM, hypertension (high blood pressure), hyperlipidemia, and anemia (a condition where the body did not have enough healthy red blood cells).</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49's cognitive skills for daily decision making was intact. The MDS indicated Resident 49 was independent for self-care and required supervision for mobility.</p> <p>During a review of Resident 49's Order Summary Report, as of 10/25/2024, the report indicated an order dated 1/22/2019 to monitor Resident 49's blood sugar before breakfast two times a week on Monday and Friday and to call the physician if the blood sugar was less than 70 milligrams (mg, unit of measurement) per (l) deciliter (dl, unit of measurement) or greater than 250 mg/dl.</p> <p>During a review of Resident 49's care plan addressing DM, revised on 5/22/2022, the care plan indicated to perform blood sugar check as ordered.</p> <p>During a concurrent interview and record review on 10/31/2024 at 10:38 a.m. with RN 1, Resident 49's MAR, for the month of October 2024, was reviewed. The MAR indicated there was no documentation for a blood sugar check on 10/25/2024 at 6:30 a.m. RN 1 stated no documentation meant the blood sugar was not performed on 10/25/2024 at 6:30 a.m.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication administration, revised on 12/19/2022, the P&P indicated to sign the MAR after medication was administered.</p> <p>During a review of the facility's P&P titled Documentation in Medical Record dated 12/19/2022, the P&P indicated documentation should be factual, objective and resident centered. The P&P indicated false information should not be documented. The P&P indicated documentation should be accurate, relevant, completed at the time of service, and timely.</p> <p>During a review of the facility's P&P titled, Provisions of Physician Ordered Services dated 5/15/2023, the P&P indicated to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. The P&P indicated medication administration and therapeutic treatments would be administered as ordered by the physician and will be administered following facility protocols, dosage guidelines, and documentation procedures.</p>		

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 10/31/2024
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff used a communication board, device, and/or interpreter services for two of 16 sampled residents (Resident 66 and 92) who did not speak the dominant language of the facility (English).</p> <p>This deficient practice had the potential to negatively affect Resident 66 and 92's physical, mental, and psychosocial needs by preventing the residents from communicating with staff and potentially causing missed or delayed care and/or treatments.</p> <p>Findings:</p> <p>a. During a review of Resident 66's Admission Record, dated 10/31/2024, the admission record indicated Resident 66 was admitted to the facility on [DATE]. Resident 66's diagnoses included fracture of the right femur (a break of the thigh bone), dysphagia (difficulty swallowing), difficulty walking, hypertension (HTN - high blood pressure), end stage renal disease (ESRD - irreversible kidney failure), sepsis (a life-threatening blood infection), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed), and a history of falling.</p> <p>During a review of Resident 66's History and Physical (H&P), dated 9/16/2024, the H&P indicated Resident 66 had a language barrier because her primary language was Korean (dominant language in the country of Korea).</p> <p>During a review of Resident 66's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/21/2024, the MDS indicated Resident 66 had moderately impaired cognitive skills (ability to think, remember and reason). The MDS indicted Resident 66 had difficulty communicating some words or finishing thoughts and understood but missed some parts or intent of verbal messages. The MDS indicated Resident 66 was independent with self-care, required setup or clean-up assistance for eating, dependent on staff with toileting and bathing, and required moderate assistance with personal hygiene.</p> <p>During a concurrent observation and interview on 10/28/2024 at 1:07 p.m. with Resident 66, in Resident 66's room, there was no communication board or device observed at Resident 66's bedside or surrounding living space. Resident 66 stated she spoke Korean and the staff did not always understand what she was saying. Resident 66 stated she had never been given a communication board or device to communicate with staff.</p> <p>During a concurrent observation and interview on 10/30/2024 at 1:24 p.m., with Resident 66, in Resident 66's room, observed Resident 66 sitting on the edge of her bed eating lunch. Resident 66 was frustrated and attempted to explain what was wrong. Resident 66 pointed to the cranberry juice on her meal tray and shook her head. There was no communication board or device observed at Resident 66's bedside and surrounding living space. Resident 66 stated, Orange juice. They don't understand me because I don't speak English! Resident 66 stated she had been asking for orange juice but the staff would not give it to her and did not understand why.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/31/2024 at 7:51 a.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 66 did not have a communication board because she spoke some English. CNA 2 stated since Resident 66's primary language was Korean, the resident (Resident 66) should have a communication board at her bedside. CNA 2 was observed looking for a communication board in Resident 66's room. CNA 2 stated Resident 66 did not have a communication board in her room but Resident 66 should have had one. CNA 2 stated it was important to have a Korean Language communication board at Resident 66's bedside so that she (Resident 66) could communicate her needs.</p> <p>During an interview on 10/31/2024 at 11:46 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 66 should have had a communication board or some type of device to assist with communication if Korean was the resident's primary language. LVN 5 stated a communication device was important so Resident 66 could communicate with staff and make her needs known. LVN 5 stated Resident 66's mood could be affected if she was unable to effectively communicate her needs to staff.</p> <p>During an interview and on 10/31/2024 at 12:43 p.m., with Registered Nurse (RN) 1, RN 1 stated the activities department as well as the MDS nurse should have assessed Resident 66 to find out her primary language and determine if a language device was required.</p> <p>49900</p> <p>b. During an observation on 10/28/2024 at 10:07 a.m., at Resident 92's bedside, there was no Spanish language communication board or device observed. Observed an unidentified staff speaking English language to Resident 92, and Resident 92 was observed nodding.</p> <p>During a review of Resident 92's Admission Record, the admission record indicated Resident 92 was originally admitted to facility on 7/12/2024. Resident 92's diagnoses included pulmonary mycobacterial infection (a lung infection caused by bacteria found in soil and water), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), chronic respiratory failure with hypoxia (a serious condition where the lungs were unable to remove enough oxygen from the blood over time), malnutrition, and sepsis.</p> <p>During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 92's preferred language was Spanish and needed an interpreter to communicate with a doctor or health care staff.</p> <p>During a review of Resident 92's H&P, dated 7/13/2024, the H&P indicated Resident 92 was Spanish speaking.</p> <p>During a review of Resident 92's care plan titled Communication language barrier speaks Spanish, revised on 7/28/2024, the care plan indicated interventions included to provide a Spanish communication board.</p> <p>During an interview on 10/30/2024 at 2:18 p.m. with LVN 4, LVN 4 stated non-English speaking residents needed a language board at the bedside for residents to communicate their needs. LVN 4 stated even though some staff spoke Spanish, the resident still needed a language communication board because not all staff spoke Spanish. LVN 4 stated it takes time to find other staff to translate which could possibly delay necessary care.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's Policy and Procedure (P&P) titled, Effective Communication, revised on 7/17/2023, the P&P indicated, It is the policy of this facility to accommodate needs when communicating with residents who have difficulties with communications to promote dignity, understanding, and safety. The P&P indicated effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including in a language that the resident can understand. The P&P indicated that staff would communicate with the resident, using techniques identified in their plan of care, and in accordance with his/her established routine for communication such as using communications boards or writing materials.</p>		

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 10/31/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on observation, interview, and record review, the facility failed to follow up on a mammogram (imaging of the breast that is used to detect and diagnose breast disease in women) appointment for one of eight sampled residents (Resident 32).</p> <p>This deficient practice resulted in Resident 32 feeling frustrated with her healthcare team and this failure had the potential to result in a delay in treatment based on the result from Resident 32's mammogram results.</p> <p>Findings:</p> <p>During a review of Resident 32's Admission Record (Face Sheet), indicated Resident 32 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 32's diagnoses included chronic kidney disease stage four (4) (a long-term condition where the kidneys are damaged and can't filter blood properly), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 32's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 8/16/2024, the MDS indicated Resident 32's cognition (process of thinking) was intact. The MDS indicated Resident 32 required set up or clean-up assistance with eating, oral hygiene, and personal hygiene and required supervision with toileting, shower, and dressing.</p> <p>During a review of Resident 32's History and Physical (H&P), dated 10/17/2024, the H&P indicated Resident 32 had the capacity to understand and make decisions.</p> <p>During a concurrent observation and interview on 10/28/2024 at 2:53 p.m., with Resident 32 in Resident 32's room, Resident 32 was observed with a hard bump under her right breast that extended to the right side of the right breast. Resident 32's underside of her right breast, where the bump was located, was a darker shade compared to Resident 32's natural skin color. Resident 32 stated she noticed the bump approximately two months ago and she informed her physician and nurses that a bump had formed under her breast. Resident 32 stated she requested a mammogram from her healthcare team, but no one had gotten back to her about an appointment date. Resident 32 stated it was important for her to have a mammogram done due to her history of breast cancer (disease that occurs when cells in the breast grow out of control). Resident 32 stated she felt frustrated that no one was taking her seriously.</p> <p>During an interview on 10/30/2024 at 10:24 a.m., with Registered Nurse (RN) 1, RN 1 stated when a physician placed an order for a resident to have a mammogram, the nursing department was responsible for calling the hospital or clinic to set up the appointment. RN 1 stated the facility would try to make an appointment based on the resident's preference and availability.</p> <p>During a concurrent interview and record review on 10/30/2024 at 10:26 a.m., with RN 1, Resident 32's Order Summary Report was reviewed. The Order Summary Report indicated the following orders:</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Mammogram screening, order date 8/21/2024.</p> <p>2. May have mammogram appointment, order date 10/18/2024.</p> <p>RN 1 stated Resident 32's physician ordered a mammogram screening in August 2024 and Resident 32 did not have a mammogram appointment set up since then. RN 1 stated Resident 32 had a history of breast cancer, and it was very important for Resident 32 to have a mammogram if she had any changes in her breasts.</p> <p>During an interview on 10/30/2024 at 10:51 a.m., with the Director of Nursing (DON), the DON stated based on the resident's insurance, different departments would handle setting up the appointments. The DON stated based on Resident 32's insurance, the nursing department was responsible for setting up the mammogram appointment. The DON stated Resident 32 had the initial order from the physician in August 2024 for a mammogram screening and the nurse at the time should have called to make the first appointment available. The DON stated following up with appointments ensured the residents received the necessary care. The DON stated the purpose of a mammogram was to find out if there were any abnormalities in the breast tissue and to rule out breast cancer. The DON stated Resident 32's mammogram appointment should have been a priority due to Resident 32's history of breast cancer and the new bump found under her breast. The DON stated because Resident 32 had not had a mammogram appointment, the facility did not know if the bump under the resident's breast was benign (not cancerous) or cancerous and they were unable to move forward with the necessary care if the bump was cancerous.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Provision of Physician Ordered Services, revised 5/15/2023, the P&P indicated, facility staff will assist residents in scheduling and attending follow-up appointments as ordered by the physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>		

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 10/31/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131</p> <p>Based on observation, interview, and record review, the facility failed to ensure precautions were maintained to prevent the development of pressure ulcers (PU, localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for three of four sampled residents (Resident 92, Residents 331, Resident 82) when the following occurred:</p> <ol style="list-style-type: none"> 1. Pressure ulcer interventions were not adequately implemented to prevent or promote the healing of Resident 82's Stage IV (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) pressure ulcer. 2. Resident 331's low air loss mattress (LALM, a mattress designed to distribute body weight over a broad surface area to help prevent skin breakdown) settings were not set to the resident's current weight. 3. Resident 92's LALM settings were not set to the resident's current weight. <p>These deficient practices had the potential to cause the avoidable development of skin breakdown and/or pressure ulcers for Residents 82, 331, and 92 and complications associated with impaired skin integrity.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 82's Admission Record, dated 10/31/2024, the admission record indicated Resident 82 was admitted to the facility on [DATE]. Resident 82's diagnoses included urinary tract infection (UTI- an infection in the bladder/urinary tract), spondylolisthesis (when a vertebra [bones that make up the spine] slips out of place and presses on the vertebra below it), and a history of falling. <p>During a review of Resident 82's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 8/20/2024, the MDS indicated Resident 82's cognition was intact (ability to think, remember and reason). The MDS indicated Resident 82 was dependent on staff for eating, oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 82 did not have a pressure reducing device for the chair.</p> <p>During a review of Resident 82's History and Physical (H&P), dated 10/7/2024, the H&P indicated Resident 82 was able to make financial and medical decisions. The H&P indicated Resident 82 had a diagnosis of quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury).</p> <p>During a review of Resident 82's Braden Scale Assessment, dated 3/8/2024, the Braden Scale Assessment indicated Resident 82 was rated at a high risk for pressure ulcer development.</p> <p>(continued on next page)</p>

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 10/31/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 82's Wound Consultant Progress Report, dated 10/24/2024, Resident 82's progress report indicated the clinician educated Resident 82 on the importance of utilizing a pad to protect bony prominences, signs and symptoms of infection and to prevent friction/shear to help achieve wound healing.</p> <p>During a review of Resident 82's care plan titled Chronic coccyx (tailbone) Stage IV pressure injury related to incontinence, immobility, non-adherence to chair times, initiated on 10/16/2024, the care plan indicated staff interventions as follows: daily wound care, encourage to participate in repositioning, encourage adherence to chair times, monitor for signs and symptoms of infections, weekly wound assessments, and notify the doctor of any changes in wound status.</p> <p>During a review of Resident 82's care plan titled The resident is resistive to care related to (r/t) refusing to adhere to 2 hour max limit for wheelchair time r/t coccyx Stage IV pressure injury, initiated 11/13/2023 and revised on 1/4/2024, the care plan indicated staff interventions which included: educate resident/family/caregivers of possible outcomes of not complying with treatment or care, give clear explanation of all care activities prior to and as they occur during each contact, if possible, negotiate a time for Activities of Daily Living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), praise resident when behavior is appropriate, and provide resident with opportunities for choice during care provision.</p> <p>During an interview on 10/30/2024 at 9:50 a.m., with Treatment Nurse (TN) 1, TN 1 stated Resident 82 refused to be taken out of the Geri chair (a reclining chair with wheels for residents who have difficulty supporting themselves in a seated position) during the day. TN 1 stated Resident 82 did not like to be in her room and chose to sit in the chair sit in the Sunshine Room every day for approximately six hours a day. TN 1 stated Resident 82 was educated on the consequences of the prolonged sitting in the Geri chair, but the resident still refused to get out of the chair during the day. TN 1 stated he provided wound care early in the morning every day because Resident 82 preferred to get out of the bed and into the Geri chair as early as possible. TN 1 stated Resident 82 was alert and oriented and had the right to refuse getting back into bed. TN 1 stated Resident 82 could have greater success at healing if she would allow some offloading (the process of reducing or removing pressure on a part of the body to help prevent or heal wound) to the PU area but the resident consistently declined to go back to bed.</p> <p>During a concurrent observation and interview on 10/30/2024 at 10:12 a.m., Resident 82 was observed lying in her Geri chair in the Sunshine Room. Resident 82 stated she preferred to be in her Geri chair all day and did not want to be in her bed.</p> <p>During a concurrent observation and interview on 10/30/2024 at 12:09 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 82 was observed sitting in her Geri chair in the Sunshine room. LVN 1 stated Resident 82 had been up in the Geri chair since 9 a.m. that morning (10/30/2024). LVN 1 stated Resident 82's certified nursing assistant (CNA) was responsible for getting the resident up and into the Geri chair after the resident's wound care. LVN 1 stated Resident 82 liked to be in the Geri chair all day but could only be in the chair for a maximum of four hours. LVN 1 stated Resident 82's weight should be shifted every 2 hours while in the chair and there should be padding to protect her PU. LVN 1 attempted to locate the padding under Resident 82 but noted that no padding had been placed under the resident. LVN 1 stated Resident 82 should have padding in her Geri chair to protect her wound and prevent further breakdown of the skin.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/2024 at 12:17 p.m., with Resident 82, Resident 82 stated sometimes the staff gave her a pillow or padding and sometimes the staff did not. Resident 82 stated she would prefer the pillows because they keep her from sliding and add more comfort. Resident 82 stated she did not refuse the padding or pillows.</p> <p>During a concurrent observation and interview on 10/30/2024 at 12:25 p.m., with CNA 5, Resident 82 was observed in her Geri chair. CNA 5 stated she Resident 82 from the bed into the Geri chair and placed padding in the chair to protect her PU. CNA 5 attempted to locate the padding but stated there was no padding in the chair. CNA 5 then stated Resident 82 refused the padding because she complained of being too hot. CNA 5 stated she did not notify the charge nurse Resident 82 refused the padding.</p> <p>During a concurrent interview and record review on 10/30/2024 at 12:37 a.m., with TN 1, Resident 84's care plan related to Pus dated 1/4/2024 and 10/16/2024 were reviewed. TN 1 stated the care plans did not have interventions for cushions, pads, or pillows to protect Resident 82's PU because TN 1 did not feel Resident 84 should have gel cushions or pillows in her Geri chair. TN 1 stated the cushions and pillows would cause Resident 82 to slide and that would cause more shearing (a horizontal force that occurs when tissue layers shift in opposite directions, which can lead to PUs). TN 1 stated there was no padding available that would fit into Resident 84's Geri chair and ill-fitted padding could be a safety issue. TN 1 stated all he could do was to encourage Resident 82 to get back in the bed and that was what he placed as interventions on Resident 82's care plan regarding PU. TN 1 admitted the PU care plans did not have any interventions to prevent break down of the skin or worsening of the pressure ulcer she already had during prolonged sitting in the Geri chair. TN 1 acknowledged that he should have consulted with the Director of Rehab to find out if there were other interventions that could have been initiated to promote healing and to prevent new pressure ulcers from developing since Resident 82 refused to get out of the Geri chair for extended periods of time during the day.</p> <p>During an observation on 10/31/2024 at 9:35 a.m., observed Resident 82's Stage IV PU to the coccyx area. The PU had a small opening that measured approximately 1.5 centimeters (CM - a metric unit used to measure length).</p> <p>During an observation on 10/31/2024 at 10:16 a.m., in Resident 82's room, observed CNA 5 and CNA 6 transfer Resident 82 from the bed to the Geri chair via Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). Resident 82's Geri chair had a cushion placed the chair was covered in the seat and with sheets. Resident 82 was placed in the chair and a pillow placed on her right side supporting her right arm.</p> <p>47679</p> <p>2. During a review of Resident 331's Admission Record (Face Sheet), the admission record indicated Resident 331 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 331's diagnoses included sepsis (a life-threatening blood infection), dementia (a progressive state of decline in mental abilities), and chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing).</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 331's MDS, dated [DATE], the MDS indicated Resident 331's cognition was severely impaired. The MDS indicated Resident 331 was dependent on staff for assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene. The MDS indicated Resident 331 utilized a pressure reducing device for a bed.</p> <p>During a review of Resident 331's H&P, dated 10/26/2024, the H&P indicated Resident 331 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 331's Braden Scale Assessment, dated 10/24/2024, the Braden Scale Assessment indicated Resident 331 was at a high risk for pressure ulcer development.</p> <p>During a review of Resident 331's Order Summary Report, active orders as of 10/31/2024, the Order Summary Report indicated to use a winged low air loss mattress for promotion of skin integrity. The Order Summary Report indicated to set to the resident's weight and comfort level. The order date was 8/3/2024.</p> <p>During an observation on 10/28/2024 at 9:45 a.m., at Resident 331's bedside, Resident 331 was observed lying on a Proactive brand Protekt Aire 6000 LALM. The LALM was set for 340 pounds (lbs., a unit of measuring weight).</p> <p>During an observation on 10/29/2024 at 8:36 a.m., at Resident 331's bedside, Resident 331 was observed lying on a Proactive brand Protekt Aire 6000 LALM. The LALM was set for 450 lbs.</p> <p>During an interview on 10/30/2024 at 9:41 a.m., with TN 1, TN 1 stated the purpose of utilizing the LALM was for pressure offloading, which moved around the pressure on the resident's body. TN 1 stated the settings for the LALM were based primarily on the resident's weight and comfort level. TN 1 stated some residents have different body shapes and the settings on the LALM would need to be adjusted to be a comfortable surface for the resident. TN 1 stated even though the LALM settings may be adjusted due to comfort, the settings would still be close to the resident's weight.</p> <p>During a concurrent observation and interview on 10/30/2024 at 9:44 a.m., with TN 1, at Resident 331's bedside, Resident 331 was observed lying on a LALM. The LALM was set for a weight of 450 lbs. TN 1 stated 450 lbs was the incorrect setting for Resident 331 because Resident 331 weighed closer to 145 lbs. TN 1 stated had checked in the morning and the setting was correct and that someone may have changed the settings on the pump while providing care to Resident 331. TN 1 stated due to the higher weight setting on the LALM pump, the mattress was inflated more than needed and was too hard of a surface. TN 1 stated Resident 331 did not have any skin breakdown and the LALM was utilized as a preventative tool, however, due to the high setting, Resident 331 was at a higher risk of developing a pressure injury (PI).</p> <p>During an interview on 10/31/2024 at 11:43 a.m., with the Director of Nursing (DON), the DON stated LALMs were used to prevent PIs and /or PUs from worsening and as a preventative intervention. The DON stated the LALM was set based on the resident's weight to ensure the mattress was not too firm for the resident. The DON stated if the setting was too high and the LALM was overinflated, the mattress would become too firm for the resident's needs. The DON stated because Resident 331's LALM was not accurately set to his weight, Resident 331 was at risk for skin breakdown and development of a PI.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49900</p> <p>3. During an observation on 10/28/2024 at 10:07 a.m., at Resident 92's bedside, Resident 92 was observed lying on a Proactive brand Protekt Aire 2000/3000 LALM. The LALM set for a weight of 350 lbs.</p> <p>During a review of Resident 92's Admission Record, the admission record indicated Resident 92 was originally admitted to facility on 7/12/2024. Resident 92's diagnoses included pulmonary mycobacterial infection (a lung infection caused by bacteria found in soil and water), COPD, chronic respiratory failure with hypoxia (a serious condition where the lungs were unable to remove enough oxygen from the blood over time), malnutrition, and sepsis.</p> <p>During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92's cognitive skills for daily decisions making was moderately impaired. The MDS indicated Resident 92 was independent with self-care. The MDS indicated Resident 92 was at risk of developing pressure ulcers.</p> <p>During a review of Resident 92's order summary report, dated 10/31/2024, the report indicated an order dated 7/16/2024 to provide a LALM for wound management and set the LALM to Resident 92's weight.</p> <p>During a review of Resident 92's skin check report, dated 10/28/2024, the report indicated Resident 92 had moisture associated skin damage (MASD - inflammation, and erosion of the skin, resulted from prolonged exposure to different sources of moisture) extending from the sacrococcyx (tailbone) to the buttocks.</p> <p>During a concurrent interview and record review on 10/30/2024 at 3:59 p.m. with TN 2, Resident 92's weights for October 2024 was reviewed. TN 2 stated Resident 92 weighed 117.0 lbs. on 10/28/2024. TN 2 stated the LALM pump reflects the resident's weight, and the purpose of the LALM was to prevent and help healing wounds. TN 2 stated the TN was responsible for checking and making sure the LALM had the right setting which matched the resident's weight. TN 2 stated if the LALM setting was too high, the LALM would be too hard which could lead to the development of PUs. TN 2 stated the wrong LALM setting delayed necessary treatments for residents.</p> <p>During an interview on 10/31/2024 at 3:59 p.m. with TN 2, TN 2 stated all Proactive LALMs used the same manual titled, Proactive Medical Products Operation Manual for Protekt Aire 4000DS/5000DX. TN 2 stated the LALM model numbers, such as 2000, 3000, and 6000, indicated the maximum weights that model could go.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention Management, revised 9/12/2023, the P&P indicated, Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but not limited to</p>		

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 10/31/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900</p> <p>Based on observation, interview, and record review, the facility failed to implement gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) orders, in accordance with facility policy, for four (4) of 4 sampled residents (Resident 56, Resident 41, Resident 35, and Resident 81) when:</p> <p>A. Resident 56 received GT feeding Glucerna (a nutrition supplement designed for people with Diabetes Mellitus [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing] or abnormal sugar) 1.2 instead of Glucerna 1.5 as ordered.</p> <p>B. Residents 81, 41 and 35 were administered medications via GT without flushing the GT line with prescribed amount of water before and after medication administration for Resident 41; not flushing GT before and after each medication administration for Resident 81; and for Residents 81, 41, and 35, GT flushing were not performed in accordance with the physician's orders and facility's policy and procedures (P&P). (Cross Reference F759)</p> <p>These deficient practices had the potential to increase the risk of malnutrition, weight loss, uncontrolled blood sugar, and pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) development for Resident 56. These deficient practices also had the potential to increase the risk of medication errors, could result in GT becoming clogged (blocked) when not flushed before and after each medication, which may require GT replacement or lead to Residents 81, 41, and 35 not receiving the full dose of each medication or feedings, as prescribed, to meet each resident's needs.</p> <p>Findings:</p> <p>1. During observation on 10/28/2024 at 3:04 p.m., in Resident 56's room, Resident 56 was receiving GT feeding Glucerna 1.2 at 65 milliliter per hour ([ml/hr] a unit of measurement) through GT.</p> <p>During a review of Resident 56's Admission Record, the Admission Record indicated Resident 56 was admitted to the facility on [DATE]. Resident 56's diagnoses included DM, muscle weakness, dysphagia (difficulty swallowing), chronic kidney disease (a condition where the kidneys were damaged and could not filter blood properly), and depression (a constant feeling of sadness and loss of interest,).</p> <p>During a review of Resident 56's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 10/4/2024, the MDS indicated Resident 56's cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 56 had impairments on extremities and had a feeding tube. The MDS indicated Resident 56 was at risk of developing pressure ulcers.</p> <p>During a review of Resident 56's care plan addressing potential nutritional problem, revised on 10/10/2024, the care plan indicated to give Glucerna 1.5 at 65 ml/hr every shift.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 10/30/24 at 10:51 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 56's Order Summary report as of 10/31/2024 was reviewed. The summary indicated an order, dated 8/27/2024, for continuous enteral feeding with Glucerna 1.5 at 65 ml/hr. LVN 4 stated LVN 4 was the one responsible for tube feeding and needed to check the order before administering the tube feeding formula to prevent mistake. LVN 4 stated Resident 56 was diabetic and Glucerna tube feeding was to control blood sugar levels. LVN 4 stated the Glucerna 1.5 could mess up Resident 56's blood sugar and calorie intake leading to weight loss and malnutrition.</p> <p>31333</p> <p>2. During a review of Resident 81's Admission Record, the Admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses including hemiplegia (is a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (stroke, when blood flow to the brain is blocked) affecting left non-dominant side, dysphagia and GT.</p> <p>During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81's cognitive skills for daily decisions making was severely impaired. The MDS indicated Resident 81 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) with facility staff for bed mobility, transferring, dressing, toileting, and personal hygiene.</p> <p>During a review of Resident 81's care plan indicated, the resident required tube feeding related to (r/t) dysphagia (difficulty swallowing), inability to meet needs orally, dated 2/12/2024, indicated to flush enteral tube with 15 ml to 30 ml before and after medication administration and 5 ml water between each medication.</p> <p>During a review of Resident 81's Order Summary Report, dated 10/29/2024, the order summary included the following:</p> <ol style="list-style-type: none"> 1. May crush medications and give via GT, order dated 8/3/2022. 2. Enteral Feed Order every shift . flush enteral tube with 15 - 30 ml water before and after medication administration and 5 ml water between each medication, order dated 1/30/2023. 3. Eliquis (apixaban) Oral Tablet 5 milligram ([mg] - unit of measure of weight), give one tablet via GT two times a day for atrial fibrillation (irregular heartbeat), order dated 3/30/2023. 4. Synthroid (levothyroxine) Oral Tablet 50 microgram ([mcg] - unit of measure of weight), give one tablet via GT one time a day for hypothyroidism, order dated 1/10/2024. 5. Lactulose Solution 10 gram ([gm] - unit of measure of weight) per 15 milliliter ([ml] - a unit of measure for volume), give 15 ml via GT three times a day for bowel management, hold for loose stools, order dated 2/16/2023. 6. Docusate Sodium (used to treat constipation) Oral Tablet 100 mg, give one tablet via GT one time a day for bowel management. Hold for loose stool, order dated 3/3/2024. <p>(continued on next page)</p>		

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 10/31/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Multivitamin with Minerals Oral Liquid, give 15 ml via GT one time a day for supplement, order dated 1/24/2024.</p> <p>8. Floranex (lactobacillus) Tablet, give one tablet via GT one time a day for GI Flora, order dated 4/27/2023.</p> <p>9. Folic Acid Oral Tablet 1 mg, give one tablet via GT one time a day for supplement, order dated 11/24/2023.</p> <p>During a concurrent MedPass observation and interview on 10/29/24, between 9:12 AM until 10:00 AM, with a LVN 1, at Nursing Station and Medication Cart (MedCart) 1A, LVN 1 prepared Resident 81's seven morning medications with a 9 AM administration time. LVN 1 crushed each pill separately and placed them in individual medication cups. LVN 1 stated that she added 25 ml of water to each medication cup and mixed. LVN 1 entered Resident 81's room to administer medication after checking GT placement and residual, LVN 1 stated and poured 40 ml of water to perform an initial flush. LVN 1 observed the GT to be clogged and then emptied the water out of the syringe, reinserted the syringe, added five ml of water to the syringe, used a plunger and pushed the five ml of water into the GT. LVN 1 stated the 5 ml of water pushed into the syringe was to clear the clogged GT. LVN 1 removed the plunger from the syringe, reattached the syringe to the GT and added 30 ml of water that flowed through the GT by gravity (no pushing), then administered each medication through the GT, one at a time without flushing before or after each medication administration. Medication residual was observed inside of each medication cup after administration.</p> <p>During an interview on 10/29/2024 at 9:57 AM, with LVN 1, LVN 1 stated, she should have mixed the medications to ensure Resident 81's medications were all administered. LVN 1 stated this was LVN 1's first time doing GT medication administration at the facility and did not have enough training. LVN 1 stated she did not flush in-between each medication administered to Resident 81 because she was taught by another nurse at the facility that putting water (25 ml water) into the crushed medication cup would be enough.</p> <p>3. During a review of Resident 41's Admission Record, the Admission Record indicated Resident 41 was admitted to the facility on [DATE] with diagnoses that included epilepsy (is a neurological condition that causes unprovoked, recurrent seizures [is a sudden rush of abnormal electrical activity in your brain]), dysphagia and long-term artificial nutrition including feeding tubes.</p> <p>During a review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41's cognitive skills for daily decisions making was severely impaired.</p> <p>During a review of Resident 41's care plan focus indicated, the resident has potential nutritional problem . new GT placement due to (d/t) inadequate oral intake and significant weight loss .care plan dated 12/6/2021 and revised 7/27/2023. Resident 41's care plan interventions included, flush enteral tube with 15-30 ml water before and after medication administration and 5 ml water between each medication.</p> <p>During a review of Resident 41's Order Summary Report, dated 10/30/2024, the order summary included the following orders:</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ol style="list-style-type: none"> 1. Enteral Feed Order every shift . flush enteral tube with 15 - 30 ml water before and after medication administration and 5 ml water between each medication, order dated 7/24/2023. 2. May crush all crushable medications, dated 8/7/2023. 3. Levetiracetam Oral Tablet 500 mg, give 10 ml via GT every 12 hours for seizures, 1000 mg per 10 ml, order dated 9/20/2024 (observed 10 ml of levetiracetam oral solution 100 mg/10 ml administered, not a 500 mg tablets on 10/30/2024) . 4. Metoprolol Tartrate 25 mg, give one half tablet (12.5 mg) via GT two times a day for hypertension ([HTN] high blood pressure). Hold for systolic blood pressure ([SBP] top number in blood pressure; pressure during active contraction of the heart) less than 110 millimeters of mercury ([mm Hg] unit used to measure BP) or heart rate (HR, beats per minute [BPM]) is less than 60 BPM, order dated 9/14/2024. 5. Plaquenil (hydroxychloroquine) Oral Tablet 200 mg, give one tablet via GT one time a day for Systemic lupus erythematosus ([SLE] an autoimmune disease that affects the whole body). 6. Oyster Shell Calcium 500 mg, give 500 mg via GT two times a day for supplement, order dated 10/14/2024. 7. Lactulose Oral Solution 10 gm/ 15 ml, give 30 ml via GT two times a day for bowel management/ elevated ammonia level, order dated 9/14/2024. 8. Vitamin D3 125 mcg (5000 International Units [IU]) Oral Tablet, give one tablet via GT one time a day for supplement, order dated 9/14/2024. 9. Pro-Stat Oral Liquid 15 gm/ 30 ml, give 30 ml via GT two times a day for supplement, order dated 9/14/2024. <p>During a concurrent MedPass observation and interview on 10/30/24 between 8:32 AM until 9:15 AM with LVN 4, at Nursing Station and MedCart 1B, LVN 4 prepared Resident 41's seven morning medications with a 9 AM administration time. LVN 4 crushed each pill separately and placed them in individual medication cups. LVN 4 stated she added 5 to 10 ml of water to each crushed pill. After checking GT placement and residual, LVN 4 administered Resident 41's medications via GT one at a time. LVN 4 poured and administer 30 ml of undiluted Pro-Stat Liquid via GT to Resident 41. LVN 4 stated, I think I need to give a little more water, 10 - 15 ml, because the Pro-Stat is very thick. LVN 4 added 5 ml of water to the Pro-Stat in the syringe, removed the syringe from Resident 41's GT and stated, I think I am done. LVN 4 was not observed flushing Resident 41's GT before starting medication administration or after completing the resident's medication administration. LVN 4 stated, that she did not do an initial flush prior to administering medications to Resident 41 and that she should have used 30 ml of water as a final flush once medication administration was completed.</p> <p>During a review of Pro-Stat manufacturer's label, indicated, use under medical supervision . Administer orally or through feeding tube .Feeding Tube:</p> <ol style="list-style-type: none"> i. Flush feeding tube with 30-60 ml of water. <p>(continued on next page)</p>		

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 10/31/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>ii. Pour 30 ml of Pro-Stat(R) into a four (4) to six (6) fluid ounce ([fl oz = 30 ml], a unit of volume) container.</p> <p>iii. Add 30-60 ml water and mix well.</p> <p>iv. Administer Pro-Stat(R) via syringe.</p> <p>v. Flush with 30-60 ml of water.</p> <p>4. During a review of Resident 35's Admission Record, the Admission Record indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 35's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia following cerebral infarction, and encounter for attention to GT.</p> <p>During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills for daily decision making was severely impaired.</p> <p>During a review of Resident 35's care plan focus indicated, the resident has potential nutritional problem . dated 9/26/2023 and revised 10/10/2024. Resident 35's care plan interventions included, flush enteral tube with 15-30 ml water before and after medication administration and 5 ml water between each medication.</p> <p>During a review of Resident 35's Order Summary Report, dated 10/30/2024, the order summary included the following:</p> <ol style="list-style-type: none"> 1. Enteral Feed Order every 4 (four) hours for hydration; Tube patency FWF (free water flow): 100 ml every 4 hours (providing 600 ml) (Total H2O [water] = 600 ml), order dated 10/9/2024. 2. Enteral Feed Order every shift . flush enteral tube with 15 - 30 ml water before and after medication administration and 5 ml water between each medication, order dated 4/22/2024. 3. May crush all crushable medications, order dated 4/22/2024. 4. Amlodipine Oral Tablet 10 mg, give one tablet via GT one time a day for HTN. Hold if SBP is less than 110 mm Hg or HR is less than 60 BPM, order dated 4/22/2024. 5. Brimonidine 0.2 percent (%) eye drop, instill one drop in both eyes three times a day for glaucoma (an eye disease that can lead to blindness), order dated 4/22/2024. 6. Ferrous Sulfate (iron supplement) 220 mg/5 ml, give 10 ml via GT two times a day for supplement, order dated 4/22/2024. 7. Levetiracetam Oral Solution 100 mg/ml, give 10 ml (1000 mg) via GT two times a day for seizure (is a sudden rush of abnormal electrical activity in your brain) disorder, order dated 4/22/2024. 8. Lisinopril Oral Tablet 40 mg, give one tablet via GT one time a day for HTN. Hold if SBP is less than 110 mm hg or HR is less than 60 BPM, order dated, 4/22/2024. <p>(continued on next page)</p>		

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 10/31/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Multivitamin & Mineral Oral Liquid. Give 15 ml via GT one time a day for supplement, order dated 4/22/2024.</p> <p>10. Senna Oral tablet 8.6 mg, give two tablets via GT two times a day for bowel management. Hold for loose stool, order dated 4/22/2024.</p> <p>11. Vitamin D3 Oral Tablet, give one tablet by mouth one time a day for supplement, order dated 5/6/2024. No strength documented on Resident 35's Order Summary Report, observed licensed nurse administer 25 mg (1000 IU) to Resident 35 on 10/30/2024.</p> <p>During a concurrent MedPass observation and interview on 10/30/24, between 9:31 AM until 10:20 AM with LVN 5, at Nursing Station and MedCart 2B, LVN 5 prepared Resident 35's eight morning medications with a 9 AM administration time. LVN 5 crushed each pill separately and placed them in individual medication cups. LVN 5 stated Resident 35 is on a pureed diet and takes medications and food through GT and by mouth for oral gratification. LVN 5 stated she will crush Resident 35's Vitamin D and give in applesauce by mouth. LVN 5 stated she added 15 ml of water to each of the remaining medication cups that contained crushed pills and mixed. After checking GT placement and residual, LVN 5 flushed Resident 35's GT with 30 ml of water, administered six out of seven crushed and liquid medications one at a time to the resident, and flushed with 30 ml of water after each administration. LVN 5 did a final flush with 30 ml of water. LVN 5 administered Vitamin D mixed with applesauce to Resident 35 by mouth followed with sips of water.</p> <p>During an interview on 10/30/2024 at 10:27 AM, with LVN 5, LVN 5 stated she flushed Resident 35's GT with 30 ml of water after each medication administration to make sure the medications were all flushed through the line clearly before administering the next medication. LVN 5 was observed using 30 ml of water to flush Resident 35's GT seven times (initial and final flush and after each medication for a total of six out of eight medications administered through the GT) for a total 210 ml of water during GT medication administration. LVN 5 stated the facility's protocol is to use 15 ml of water to flush the resident's GT before and after each medication administration. However, Resident 35's physician order indicated to use 5 ml of water to flush in-between each medication administered via GT to the resident.</p> <p>During an interview on 10/31/2024 at 12:45 PM, with the Director of Staff Development (DSD), the DSD stated licensed nurses use 5 ml to 15 ml of water to flush the resident's GT after each medication administration. The DSD stated flushing a resident's GT with 30 ml of water between each medication would be a lot. DSD stated the licensed nurses are to flush with 30 ml of water prior to medication administration and 30 ml of water after completing medication administration, but not 30 ml of water in-between each medication which could cause a fluid overload for the resident. The DSD reviewed the GT training records for LVN 1, LVN 4, and LVN 5. The DSD stated LVN 5's Enteral Feeding Checklist and training was done on 10/2/2024. The DSD stated there was no record of LVN 1 or LVN 4 having completed Enteral Feeding Checklist and training.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/31/2024 at 1:50 PM, with the Regional Nurse Consultant (RNC), in the presence of the Director of Nursing (DON), inside the DON's office, RNC stated the standard of practice for GT medication administration is to flush the GT with 30 ml of before and after medication administration and to flush the GT with 15 ml of water in-between each medication administered through the GT. RNC stated not flushing the GT in-between medication administration could cause the GT to clog, medications may not be properly diluted, and residents may not receive the full dose of medications. RNC stated flushing the GT before medication administration ensures the patency (is assessing the GT with water to ensure it is not clogged) of the GT and flushing the GT after medication administration prevents the GT from clogging.</p> <p>During a concurrent interview and record review on 10/31/2024 at 2:01 PM, with RNC, Resident 35, Resident 81, and Resident 41's Order Summary Report were reviewed. Resident 35's physician order indicated to flush the resident's GT with 15 to 30 ml of water before and after medication administration and to flush with 5 ml of water between each medication. RNC stated flushing with 30 ml of water in-between each medication is not in accordance with the physician's order. RNC stated Resident 81 and Resident 41 both had the same physician order as Resident 35 for the amount of water to use in flushing the GT. RNC stated the facility's procedure is to follow the physician's orders which indicated to flush with 5 ml of water in-between each medication administered via GT.</p> <p>During a review of the facility's P&P titled, Care and treatment of feeding tubes, revised 12/19/2022, the P&P indicated feeding tubes would be utilized according to physician orders, included the kind of feeding.</p> <p>During a review of facility's P&P titled, Medication Administered via Enteral Tube, revised 12/19/2022, the P&P indicated to verify physician orders for medication and enteral tube flush amount .Flush enteral tube with at least 15 ml of water prior to administering medications unless otherwise ordered by prescriber .Dilute solid or liquid medication as appropriate and administer using a clean oral syringe .Flush tube with at least 15 ml water taking into account resident's volume status. Repeat with the next medication (if appropriate). Flush the tube with a final flush of at least 15 ml of water to ensure drug (medication) delivery and clear the tube.</p> <p>During a review of facility P&P titled, Flushing a Feeding Tube, revised 12/19/2022, the P&P indicated, it is the policy of this facility to ensure that staff providing care and services to the resident via a feeding tube are aware of, competent in and utilize facility protocols regarding feeding nutrition and care. Feeding tube care and services will be provided in accordance with resident needs and professional standards of practice .After tube placement has been verified, flush the tube utilizing the 60 ml catheter tip syringe with the prescribed amount of water, as directed by the physician.</p>		

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 10/31/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009</p> <p>Based on observation, interview, and record review the facility failed to implement safe oxygen administration practices, for three of 16 sampled residents (Residents 14, 54, and 99), by failing to ensure:</p> <ol style="list-style-type: none"> 1. Resident 14's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was dated with an open date. 2. Precautionary (warning) sign was posted outside of Resident 14, Resident 54, and Resident 99's room, who were using oxygen. 3. Resident 14 and Resident 54's nasal cannula was not touching the floor. <p>These deficient practices had the potential to Residents 14 and 54 to acquire respiratory infection and placed Residents 14, 54 and 99, at risk for injuries due to fire hazard.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 10/28/2024 at 11:28 a.m. in Resident 54's room, Resident 54's nasal cannula was touching the floor. Outside of Resident 54's room had no sign indicating oxygen was in use. <p>During an observation on 10/29/2024 at 12:58 p.m. in Resident 54's room, Resident 54's nasal cannula was touching the floor. Outside of Resident 54's room had no sign indicating oxygen was in use.</p> <p>During an observation on 10/30/2024 at 10:50 a.m. in Resident 54's room, Resident 54's nasal cannula tubing was touching the floor.</p> <p>During a review of Resident 54's Admission Record, the Admission Record indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted to facility on 12/13/2020 with a diagnosis of chronic kidney disease (gradual loss of kidney function, kidneys are unable to filter wastes and excess fluids from blood) and cardiomegaly (a condition where the heart becomes enlarged, or larger than normal).</p> <p>During a review of Resident 54's History and Physical (H&P) dated 4/11/2024, the H&P indicated Resident 54 did not have the capacity to make medical decisions.</p> <p>During a review of Resident 54's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/24/2024, the MDS indicated that Resident 54's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 54 needed moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. The MDS indicated Resident 54 was dependent on staff for dressing, toileting hygiene and putting and taking off footwear.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During observation on 10/28/2024 at 2:05 p.m., outside Resident 99's room, the door did not have precautionary sign of oxygen in use. Resident 99 had oxygen concentrator (a medical device that extracted oxygen from the air and delivered it to resident for breathing) at bedside.</p> <p>During observation on 10/29/2024 at 3:09 p.m., outside Resident 99's room, there was no precautionary sign on the door for oxygen use. Resident 99 had oxygen concentrator at bedside.</p> <p>During a concurrent observation and interview on 10/30/2024 at 9:31 a.m. with Registered Nurse (RN) 1, outside Resident 99's room, there was no precautionary sign on the door for oxygen use. Resident 99 had oxygen concentrator at bedside. RN 1 stated Resident 99 should have a no smoking sign outside the room for everyone's safety. RN 1 stated the purpose of the no smoking sign on the door was to make sure no one smoke when the oxygen was on. RN 1 stated it was everyone's responsibility to ensure there was a no smoking sign outside the room. RN 1 stated the potential risk of not having the precautionary sign was fire.</p> <p>During a review of Resident 99's Admission Record, the Admission Record indicated Resident 99 was originally admitted to facility on 5/23/2023 and readmitted on [DATE]. Resident 99's diagnoses included respiratory failure (a condition in which your blood didn't have enough oxygen or had too much carbon dioxide, and making it difficult to breathe properly), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), pulmonary edema (a condition where too much fluid builds up in the lungs, making it difficult to breathe), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 99's H&P dated 1/31/2024, the H&P indicated Resident 99 did not have mental capacity to make medical decisions.</p> <p>During a review of Resident 99's MDS dated [DATE], the MDS indicated Resident 99's cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired. The MDS indicated Resident 99 had no impairment on upper extremities.</p> <p>During a review of Resident 99's Order Summary report, as of 10/31/2024, the order summary indicated an order to have continuous oxygen for shortness of breath on 10/8/2024.</p> <p>49900</p> <p>3. During an observation on 10/28/2024 at 2:55 p.m. in Resident 14's room, Resident 14's nasal cannula was not dated. Resident 14's nasal cannula tubing was touching the floor. Outside of Resident 14's room had no sign indicating oxygen was in use.</p> <p>During an observation on 10/30/2024 at 10:57 a.m. in Resident 14's room, Resident 14's nasal cannula was not dated. Resident 14's nasal cannula tubing was touching the floor.</p> <p>During an observation on 10/31/2024 at 9:08 a.m. in Resident 14's room, Resident 14's nasal cannula was not dated. Resident 14's nasal cannula tubing was touching the floor.</p> <p>During a review of Resident 14's Admission Record, indicated Resident 14 was admitted to the facility on [DATE] with a diagnosis of obstructive sleep apnea (Intermittent airflow blockage during sleep) and COPD.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 14's H&P dated 9/15/2024, the H&P indicated Resident 14 had the mental capacity to make medical decisions.</p> <p>During a review of Resident 14's MDS dated [DATE], the MDS indicated that Resident 14's cognitive skills for daily decision making was intact. The MDS indicated Resident 14 needed moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. The MDS indicated Resident 14 was dependent on staff for dressing, toileting hygiene and putting and taking off footwear.</p> <p>During an interview on 10/30/2024 at 2:07 p.m. with Infection Preventionist Nurse (IPN), the IPN stated oxygen administration equipment must be dated with open date and nurse's initials. The IPN stated it was important to date all oxygen equipment because all equipment was only good for 1 week and staff must know when to replace it. The IPN stated if equipment was not dated, staff would not be able to prevent a respiratory infection. The IPN stated a nasal cannula tubing should never touch the floor for infection prevention. The IPN stated if nasal cannula tubing touched the floor, it had to be replaced. The IPN stated as a safety measure, all residents on oxygen therapy must have a sign outside their room, indicating oxygen was in use. The IPN stated, an oxygen in use sign, served a reminder for staff, residents and visitors not to smoke near those rooms with a sign.</p> <p>During an interview on 10/31/2024 at 12:40 p.m. with Registered Nurse (RN 1), RN 1 stated, nurses must use clean oxygen equipment for all residents. RN 1 stated oxygen equipment must be dated with open date, to show the date oxygen equipment was opened and to guide nurses, when equipment must be changed. RN 1 stated for infection prevention, all oxygen tubing must not touch the floor and oxygen equipment must be dated. RN 1 stated for safety, all rooms with residents on oxygen, must display an oxygen in use sign, outside their room.</p> <p>During a review of facility's Policy and Procedure (P&P) titled Oxygen Administration, dated 5/20/2024, the P&P indicated an oxygen warning sign must be placed on the door of the resident's room where oxygen is in use. The P&P indicated oxygen tubing would be changed weekly and as needed if it becomes soiled or contaminated.</p> <p>During a review of facility's P&) titled, Oxygen Safety, revised 12/19/2022, the P&P indicated precautionary signs readable from 5 feet shall be maintained on the door or gate where oxygen was used or stored. The P&P indicated an example of precautionary sign was oxygen stored within - no smoking.</p>		

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 10/31/2024
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper use of bedrails (adjustable metal or rigid plastic bars that attach to the bed) for one of eight sampled residents (Resident 331) as indicated in the facility's policy and procedure (P&P) by failing to:</p> <ol style="list-style-type: none"> 1. Assess Resident 331's risk for entrapment (the state of being caught in or as in a trap). 2. Assess Resident 331's need for bedrails. 3. Conduct monitoring specific to Resident 331's use of bedrails. <p>These deficient practices had the potential to result in an accident such as a body part being caught between the bedrails, entrapment, and/or a fall if Resident 331 were to attempt to climb over, around, between, or through the bedrails.</p> <p>Findings:</p> <p>During a review of Resident 331's Admission Record (Face Sheet), indicated Resident 331 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 331's diagnoses included sepsis (a life-threatening blood infection), dementia (a progressive state of decline in mental abilities), and chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing).</p> <p>During a review of Resident 331's Minimum Data Set ([MDS], a federally mandated resident assessment tool), dated 8/25/2024, the MDS indicated Resident 331's cognition (process of thinking) was severely impaired. The MDS indicated Resident 331 was dependent on staff for assistance with oral hygiene, toileting, bathing, dressing, and personal hygiene.</p> <p>During a review of Resident 331's History and Physical (H&P), dated 10/26/2024, the H&P indicated Resident 331 did not have the capacity to understand and make decisions.</p> <p>During an observation on 10/28/2024 at 9:45 a.m. and on 10/29/2024 at 8:36 a.m., in Resident 331's room, Resident 331 was observed lying in bed with bilateral (both sides) bedrails up.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/31/2024 at 8:19 a.m., with Registered Nurse (RN) 1, RN 1 stated bed rails were utilized only if they were beneficial for the resident such as a mobility aid. RN 1 stated prior to placing the bedrails, the nurse was responsible for determining if the resident needed them. RN 1 stated the resident would also be assessed on their risk for entrapment from the bedrails. RN 1 stated the risk for entrapment increased with the use of bedrails and the resident would have to be monitored closely to ensure safety. RN 1 stated the nurses and nurse aids would be made aware that bedrails were being utilized and would ensure properly monitoring and positioning at least every two hours. RN 1 stated once the assessment was completed, the resident's physician would place the order for bedrails and would speak with the resident and/or their responsible party (RP) to discuss the risks and benefits of the use of bedrails.</p> <p>During a concurrent observation and interview on 10/31/2024 at 8:23 a.m., with RN 1, in Resident 331's room, Resident 331 was observed in bed with bilateral bedrails. RN 1 stated Resident 331 was unable to move on his own and he should not have bedrails.</p> <p>During a concurrent interview and record review on 10/31/2024 at 8:24 a.m., with RN 1, Resident 331's Orders were reviewed. The Orders did not indicate that Resident 331's physician ordered the use of bedrails. RN 1 stated without a physician's order for bedrails, the bedrails should not have been placed for Resident 331.</p> <p>During a concurrent interview and record review on 10/31/2024 at 8:26 a.m., with RN 1, Resident 331's Bed Rails Assessment, dated 5/23/2024 was reviewed. The Bed Rails Assessment indicated bedrails were not indicated as Resident 331 was unable to move on his own. RN 1 stated Bed Rail Assessments were done prior to placing bedrails and quarterly to ensure the resident was properly assessed for the need for bedrails, the effectiveness of alternative interventions, and the resident's risk for entrapment. RN 1 stated on 5/23/2024 Resident 331 was assessed for the use of bedrails, and the use of bedrails was not indicated at the time. RN 1 stated Resident 331's mobility status had not changed and was unable to move on his own. RN 1 stated if Resident 331 had been assessed for bed rails, currently, the use of bedrails would not be indicated.</p> <p>During an interview on 10/31/2024 at 8:29 a.m., with RN 1, RN 1 stated Resident 331 had bilateral bedrails, however, they did not follow the process of assessing Resident 331's need for bedrails, Resident 331's risk for entrapment, and performing close monitoring specific to Resident 331's bedrails. RN 1 stated the main priority when a resident had bedrails was safety, to prevent avoidable falls and entrapment between the bedrail and the bed.</p> <p>During an interview on 10/31/2024 at 11:47 a.m., with the Director of Nursing (DON), the DON stated when a resident was admitted to the facility, the licensed nurse would assess the resident and see if it was safe to utilize bedrails. The DON stated an assessment was not done prior to placing bedrails for Resident 331 which placed Resident 331 at risk for entrapment within the bedrails and Resident 331 may not be able to safely utilize the bedrails. The DON stated proper monitoring and assessment were needed to ensure safe use of bedrails.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Proper Use of Bed Rails, revised 12/19/2022, the P&P indicated, the resident assessment must include an evaluation of the alternatives that were attempted prior to the installation of a bed rail and how these alternatives failed to meet the resident's assessed needs, the resident's risk from using bed rails, and the resident's risk of entrapment between the mattress and bed rails. The facility will document the direct monitoring and supervision provided during the use of bed rails.</p>		

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 10/31/2024
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009</p> <p>Based on observation, interview, and record review, the facility failed to ensure licensed nurses were trained on the use of a bilevel positive airway pressure ([BIPAP], noninvasive ventilation mask that helps a person breathe, a treatment to provide oxygen and get rid of carbon dioxide) machine for one out of eight sampled residents (Resident 14).</p> <p>This deficient practice prevented Resident 14 from receiving the benefits of BIPAP therapy and placed Resident 14 at risk for respiratory complications during her sleep.</p> <p>Findings:</p> <p>During a review of Resident 14's Admission Record, the admission record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnoses included obstructive sleep apnea (Intermittent airflow blockage during sleep) and chronic obstructive pulmonary disease ([COPD] group of chronic lung diseases that block airflow and make it harder to breathe air out of the lungs).</p> <p>During a review of Resident 14's History and Physical (H&P) dated 9/15/2024, the H&P indicated Resident 14 had the mental capacity to make medical decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/14/2024, the MDS indicated Resident 14's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was intact. The MDS indicated Resident 14 required moderate assistance (helper does less than half the effort) for oral hygiene and personal hygiene. The MDS indicated Resident 14 was dependent on staff for dressing, toileting hygiene and putting on and taking off footwear.</p> <p>During a review of Resident 14's Order Summary Report dated 9/11/2024, the order summary report indicated Resident 14 had an order for BIPAP machine at bedtime for COPD/obstructive sleep apnea.</p> <p>During a review of Resident 14's Care plan for BIPAP therapy dated 9/16/2024, the care plan indicated the goal for Resident 14 was to adhere to the BIPAP regimen. The care plan indicated the staff's interventions were to educate Resident 14 on the importance of BIPAP therapy and to encourage Resident 14 to use the BIPAP machine.</p> <p>During an interview on 10/28/2024 at 2:55 p.m. with Resident 14, in Resident 14's room, Resident 14 stated she knew she had an order for the use of a BIPAP machine every night but the nurses did not provide the BIPAP machine to her. Resident 14 stated the nurses told her they did not provide the BIPAP machine because they did not know how to use the BIPAP machine. Resident 14 stated she wanted to use the BIPAP machine because she knew she needed it while sleeping but the nurses refused to help her.</p> <p>During an interview on 10/30/2024 at 10:57 a.m. with Resident 14, Resident 14 stated the nurses did not offer the use of the BIPAP machine last night (10/29/2024). Resident 14 stated she was worried while sleeping because she has sleep apnea and needed the BIPAP machine.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/2024 at 4:02 p.m. with Licensed Vocational Nurse (LVN 8), LVN 8 stated he never used Resident 14's BIPAP machine. LVN 8 stated he knew Resident 14 had an order for BIPAP but never put it on Resident 14. LVN 8 stated he documented Resident 14's use of the BIPAP machine because he was in a hurry and was busy. LVN 8 stated it was wrong to document Resident 14 received the BIPAP machine when she did not because it was a lie. LVN 8 stated it was important for Resident 14 to use her BIPAP machine because she needed it while sleeping. LVN 8 stated the facility had not in-serviced him on how to use the BIPAP machine. LVN 8 stated he did not know how often the BIPAP equipment was replaced or how often the water in the BIPAP machine was replaced.</p> <p>During an interview on 10/30/2024 at 4:17 p.m. with LVN 9, LVN 9 stated Resident 14 needed the BIPAP machine because Resident 14 had sleep apnea and needed that extra oxygen while sleeping. LVN 9 stated she had not provided the BIPAP machine to Resident 14 because it had a missing piece. LVN 9 stated she did not inform anyone that there was a missing piece and she did not notify Resident 14's physician Resident 14 did not use her BIPAP machine. LVN 9 stated she had never provided the BIPAP machine to Resident 14 but documented that she did. LVN 9 stated she should not have documented Resident 14's use of the BIPAP machine because it was inaccurate. LVN 9 stated the facility had not provided her with an in-service on how to use a BIPAP machine. LVN 9 stated she did not know how often BIPAP equipment was replaced or how often the water in the BIPAP machine was replaced. LVN 9 stated she did not know if the facility had extra BIPAP equipment for use.</p> <p>During an interview on 10/31/2024 at 12:40 p.m. with Registered Nurse (RN 1), RN 1 stated residents with respiratory issues while sleeping needed a BIPAP machine while sleeping. RN 1 stated Resident 14 could potentially have difficulty breathing or would have shortness of breath while sleeping. RN 1 stated if a nurse did not know how to use a BIPAP machine they should ask for help. RN 1 stated licensed nurses should be trained to use a BIPAP machine. RN 1 stated licensed nurses must follow the physician's orders and if they did not, they must inform the physician.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Noninvasive Ventilation (BIPAP), dated 12/19/2022, the P&P indicated it was the facility's policy to provide noninvasive ventilation as per the physician's order and current standards of practice.</p> <p>During a review of the facility's P&P titled, Provisions of Physician Ordered Services dated 5/15/2023, the P&P indicated to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. The P&P indicated medication administration and therapeutic treatments would be administered as ordered by the physician and will be administered following facility protocols, dosage guidelines, and documentation procedures.</p>		

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 10/31/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49900</p> <p>Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) prior to administering Seroquel (a medication used to treat several kinds of mental health conditions) to Resident 118 at bedtime on 10/29/2024.</p> <p>This deficient practice had the potential to result in Resident 118 and his responsible party's (RP) unawareness of adverse effects (unwanted, uncomfortable, or dangerous effects that a drug might have) related to the medication therapy and may cause impairment or decline in mental, physical condition, functional, and/or psychosocial status of the resident.</p> <p>Findings:</p> <p>During a review of Resident 118's Admission Record, the admission record indicated Resident 118 was admitted to the facility on [DATE]. Resident 118's diagnoses included sepsis (a life-threatening blood infection), dysphagia (difficulty swallowing), depression (a constant feeling of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 118's History and Physical (H&P), dated 6/13/2024, the H&P indicated Resident 118 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 118's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/12/2024, the MDS indicated Resident 118's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making was severely impaired. The MDS indicated Resident 118 was dependent on staff for personal hygiene, toileting hygiene, toilet transfer, and tub/shower transfer.</p> <p>During a review of Resident 118's order summary report, dated 10/31/2024, the report indicated Seroquel 12.5 milligrams (mg, unit of measurement) at bedtime was ordered on 10/29/2024.</p> <p>During a concurrent interview and record review on 10/30/2024 at 2:03 p.m. with Registered Nurse (RN) 1, Resident 118's Medication Administration Record (MAR) for October 2024 was reviewed. The MAR indicated Resident 118 received Seroquel 12.5 mg at bedtime on 10/29/2024. RN 1 stated there was no informed consent for Seroquel 12.5mg at bedtime.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/30/2024 at 2:09 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated licensed nurse needed to make sure there was informed consent for antipsychotic medication prior to administration. LVN 4 stated if there was no informed consent, the nurse needed to call resident's family/ RP to obtain consent. LVN 4 stated antipsychotics (medications used to treat mental illness) could alter resident in many ways, and the nurse needed to make sure the resident and their RP were aware of the adverse effects. LVN 4 stated resident might have adverse effects, and the RP might not be aware of the adverse effects without the informed consent which could possibly delay necessary care. LVN 4 stated the licensed nurse was responsible for obtaining the informed consent, and the informed consent should be done when the medication was ordered. LVN 4 stated Seroquel 12.5 mg should not have been given if there was no informed consent.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Informed consent, revised on 3/25/2024, the P&P indicated When situations arise that involve complex decisions, the facility will verify that informed consent has been obtained prior to any medical intervention or treatment is initiated, including, but not limited to, administration of psychotherapeutic medication.</p>		

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 10/31/2024
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent (%). Eight medication errors out of 31 total opportunities contributed to an overall medication error rate of 25.81% for two of six residents (Resident 81 and Resident 41) observed during medication administration (MedPass). The facility failed to ensure: (Cross Reference F693)</p> <p>A. Resident 81's gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition and/or medication directly to the stomach) was flushed after each medication administration and the resident was administered the full dosages of each medication as ordered on 10/29/2024 for the scheduled 9 AM administration.</p> <p>B. Resident 41's GT was flushed before administering medication and again upon completion of medication administration as ordered.</p> <p>The deficient practice of failing to administer medications in accordance with the physician orders increased the risk that Resident 81 and Resident 41 may experience adverse reactions, complications, that could lead to a decline in the resident's condition, harm, or hospitalization .</p> <p>Findings:</p> <p>1. During a review of Resident 81's Admission Record (a document containing diagnostic and demographic information), the admission record indicated Resident 81 was admitted to the facility on [DATE]. Resident 81's diagnoses included hemiplegia (is a severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (is a mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (stroke, when blood flow to the brain is blocked) affecting the left non-dominant side, dysphagia (difficulty swallowing) and encounter for attention to GT.</p> <p>During a review of Resident 81's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 7/29/2024, the MDS indicated Resident 81's cognitive skills for daily decisions making was severely impaired (ability to think and reason). The MDS indicated Resident 81 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity) upon facility staff for bed mobility, transferring, dressing, toileting, and personal hygiene.</p> <p>During a review of Resident 81's care plan indicated, The resident requires tube feeding r/t (related to) dysphagia, inability to meet needs orally . The care plan indicated staff were to flush the resident's enteral tube with 15 milliliter ([ml] - a unit of measure for volume) to 30 ml before and after medication administration and 5 ml water between each medication, care plan dated 2/12/2024.</p> <p>During a review of Resident 81's Order Summary Report, dated 10/29/2024, included the following orders:</p> <p>1. May crush medications and give via GT, order dated 8/3/2022.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Enteral Feed Order every shift . flush enteral tube with 15 - 30 ml water before and after medication administration and 5 ml water between each medication, order dated 1/30/2023.</p> <p>i. Eliquis (apixaban, a blood thinner) Oral Tablet 5 milligram ([mg] - unit of measure of weight), give one tablet via GT two times a day for atrial fibrillation (irregular heartbeat), order dated 3/30/2023.</p> <p>ii. Synthroid (levothyroxine, medication used to treat hypothyroidism) Oral Tablet 50 microgram ([mcg] - unit of measure of weight), give one tablet via GT one time a day for hypothyroidism, order dated 1/10/2024.</p> <p>iii. Lactulose (used to treat constipation) Solution 10 gram ([gm] - unit of measure of weight) per 15 ml, give 15 ml via GT three times a day for bowel management, hold for loose stools, order dated 2/16/2023.</p> <p>iv. Docusate Sodium (used to treat constipation) Oral Tablet 100 mg, give one tablet via GT one time a day for bowel management. Hold for loose stool, order dated 3/3/2024.</p> <p>v. Multivitamin with Minerals Oral Liquid, give 15 ml via GT one time a day for supplement, order dated 1/24/2024.</p> <p>vi. Floranex (lactobacillus, probiotics which are live bacteria and yeasts) Tablet, give one tablet via GT one time a day for gastrointestinal (GI, refers to the gastrointestinal tract and the organs that aid digestion) Flora, order dated 4/27/2023.</p> <p>vii. Folic Acid (vitamin, helps the body make new cells) Oral Tablet 1 mg, give one tablet via GT one time a day for supplement, order dated 11/24/2023.</p> <p>During a concurrent MedPass observation and interview on 10/29/2024 between 9:12 AM until 10:00 AM with Licensed Vocational Nurse (LVN) 1 on Nursing Station and Medication Cart (MedCart) 1A, LVN 1 prepared Resident 81's seven morning medications with a 9 AM administration time. LVN 1 crushed each pill separately and placed them in individual medication cups. LVN 1 stated that she added 25 ml of water to each medication cup and mixed. LVN 1 entered Resident 81's room to administer medication after checking GT placement and residual (something left behind). LVN 1 stated and poured 40 ml of water to perform an initial flush. LVN 1 observed the GT to be clogged and then emptied the water out of the syringe, reinserted the syringe added five ml of water to the syringe, used a plunger and pushed the five ml of water into the GT. LVN 1 stated the 5 ml of water pushed into the syringe was to clear the GT clog. LVN 1 removed the plunger from the syringe, reattached the syringe to the GT and added 30 ml of water that flowed through the GT by gravity (no pushing), then administered each medication through the GT, one at a time without flushing before or after each medication administration. Medication residual was observed inside of each of the six medication cups after administration that included the following medications, Eliquis, levothyroxine, lactulose, docusate Sodium, multivitamin, folic acid, plus a probiotic, lactobacillus.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/29/2024 at 9:57 AM, with LVN 1, LVN 1 stated, she should have mixed the medications more to ensure Resident 81 was administered all of the medications. LVN 1 stated this was LVN 1's first time doing GT medication administration at the facility and did not have enough training. LVN 1 stated she did not flush in-between each medication administered to Resident 81 because she was taught by another nurse at the facility that putting water (25 ml water) into the crushed medication cup would be enough.</p> <p>2. During a review of Resident 41's Admission Record, the admission record indicated Resident 41 was admitted to the facility on [DATE]. Resident 41's diagnoses included epilepsy (is a neurological condition that causes unprovoked, recurrent seizures [is a sudden rush of abnormal electrical activity in your brain]), dysphagia and long-term artificial nutrition including feeding tubes.</p> <p>During a review of Resident 41's MDS, dated [DATE], the MDS indicated Resident 41's cognitive skills for daily decision making was severely impaired.</p> <p>During a review of Resident 41's care plan focus indicated, The resident has potential nutritional problem . new GT placement d/t (due to) inadequate oral intake and significant weight loss .care plan, dated 12/6/2021 and revised 7/27/2023. Resident 41's care plan interventions included, flush enteral tube with 15-30 ml water before and after medication administration and 5 ml water between each medication.</p> <p>During a review of Resident 41's Order Summary Report, dated 10/30/2024, included the following orders:</p> <ol style="list-style-type: none"> 1. Enteral Feed Order every shift . flush enteral tube with 15 - 30 ml water before and after medication administration and 5 ml water between each medication, order dated 7/24/2023. 2. May crush all crushable medications, dated 8/7/2023. <ol style="list-style-type: none"> i. Levetiracetam Oral Tablet 500 mg, give 10 ml via GT every 12 hours for seizures, 1000 mg per 10 ml, order dated 9/20/2024 (observed 10 ml of levetiracetam oral solution 100 mg/10 ml administered, not a 500 mg tablets on 10/30/2024) . ii. Metoprolol Tartrate 25 mg, give one half tablet (12.5 mg) via GT two times a day for hypertension ([HTN] high blood pressure). Hold for systolic blood pressure ([SBP] top number in blood pressure; pressure during active contraction of the heart) less than 110 millimeters of mercury ([mm Hg] unit used to measure BP) or heart rate (HR, beats per minute [BPM]) is less than 60 BPM, order dated 9/14/2024. iii. Plaquenil (hydroxychloroquine, used to treat certain autoimmune diseases) Oral Tablet 200 mg, give one tablet via GT one time a day for Systemic lupus erythematosus ([SLE] an autoimmune disease that affects the whole body). iv. Oyster Shell Calcium (used to prevent or treat low blood calcium levels) 500 mg, give 500 mg via GT two times a day for supplement, order dated 10/14/2024. v. Lactulose Oral Solution 10 gm/ 15 ml, give 30 ml via GT two times a day for bowel management/ elevated ammonia level, order dated 9/14/2024. <p>(continued on next page)</p>		

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 10/31/2024
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>vi. Vitamin D3 125 mcg (5000 International Units [IU]) Oral Tablet, give one tablet via GT one time a day for supplement, order dated 9/14/2024.</p> <p>vii. Pro-Stat (concentrated liquid protein) Oral Liquid 15 gm/ 30 ml, give 30 ml via GT two times a day for supplement, order dated 9/14/2024.</p> <p>During a concurrent MedPass observation and interview on 10/30/2024 between 8:32 AM until 9:15 AM with LVN 4 on Nursing Station and MedCart 1B, LVN 4 prepared Resident 41's seven morning medications with a 9 AM administration time. LVN 4 crushed each pill separately and placed them in individual medication cups. LVN 4 stated she added 5 to 10 ml of water to each crushed pill. After checking GT placement and residual LVN 4 administered Resident 41's medications via GT one at a time. LVN 4 poured and administer 30 ml of undiluted Pro-Stat Liquid via GT to Resident 41. LVN 4 stated, I think I need to give a little more water 10 - 15 ml because the Pro-Stat is very thick. LVN 4 added 5 ml of water to the Pro-Stat in the syringe, removed the syringe from Resident 41's GT and stated, I think I am done. LVN 4 was not observed flushing Resident 41's GT before starting medication administration or after completing the resident's medication administration. LVN 4 stated, that she did not do an initial flush prior to administering medications to Resident 41 and that she should have used 30 ml of water as a final flush once medication administration was completed.</p> <p>During an interview on 10/31/2024 at 1:50 PM, in the presence of the Director of Nursing (DON), with the Regional Nurse Consultant (RNC) inside of the DON's office, the RNC stated the standard of practice for GT medication administration was to flush the GT with 30 ml of before and after medication administration and to flush the GT with 15 ml of water in-between each medication administered through the GT. The RNC stated not flushing the GT in-between medication administration could cause the GT to clog, medications may not be properly diluted, and residents may not receive the full dose of medications. RNC stated flushing the GT before medication administration ensures the patency (is assessing the GT with water to ensure it is not clogged) of the GT and flushing the GT after medication administration prevents the GT from clogging.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Administered via Enteral Tube, revised on 12/19/2022, the P&P indicated Verify physician orders for medication and enteral tube flush amount .Flush enteral tube with at least 15 ml of water prior to administering medications unless otherwise ordered by prescriber .Dilute solid or liquid medication as appropriate and administer using a clean oral syringe (> 30mL in size). Flush tube again with at least 15 ml water taking into account resident's volume status. Repeat with the next medication (if appropriate). Flush the tube with a final flush of at least 15 ml of water to ensure drug (medication) delivery and clear the tube.</p> <p>During a review of facility P&P titled, Flushing a Feeding Tube, revised on 12/19/2022, the P&P indicated, After tube placement has been verified, flush the tube utilizing the 60 ml catheter tip syringe with the prescribed amount of water, as directed by the physician.</p>		

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 10/31/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of six sampled residents' medication regimen was free from significant medication errors (Resident 36 and Resident 55).</p> <p>This deficient practice jeopardized Resident 36 and Resident 55's health and safety by failing to administer necessary medications in accordance with the physician order, manufacturer's specification, and notifying physician when medication was not administered as prescribed to meet the needs of the residents.</p> <p>Findings:</p> <p>1. During a review of Resident 36's Admission Record (a document containing diagnostic and demographic information), the admission record indicated Resident 36 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 36's diagnoses included Type II diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar [BS] control) and hypertension (high blood pressure).</p> <p>During a review of Resident 36's Minimum Data Set (MDS), a federally mandated assessment tool, dated 10/14/2024, the MDS indicated Resident 36's cognitive skills for daily decisions making was moderately impaired (ability to think and reason).</p> <p>During a review of Resident 36's care plan focus indicated, The resident has Diabetes Mellitus .care plan, dated 10/17/2024. Resident 36's care plan goals included the resident will be free from any signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar), and have no complications related to diabetes. Staff interventions included diabetes medication as ordered by doctor and monitor/document for side effects and effectiveness.</p> <p>During a review of Resident 36's Order Summary Report, for orders dated 10/7/2024, included the following orders:</p> <p>1. Enteral Feed Order every shift Enteral Feeding: Formula: Glucerna (a meal replacement or supplement made specifically for individuals with diabetes) 1.5 calories, Rate: 70 milliliter (ml, a measure of volume) per hour (hr) to provide 1400 ml total, 2100 kilocalories (kcal, are used to describe the energy content of food), 116 grams (g, a measure of weight) of protein, 1063 water (H2O) Start at: 1300 (1:00 PM) Off at: 0900 (9:00 AM) or until dose complete.</p> <p>2. Humulin R (insulin, a hormone that removes excess sugar from the blood) Injection Solution 100 UNIT ([U] is a standard measure of a substance) per ml (Insulin Regular (Human)) Inject as per sliding scale: if (BS, measured in milligrams per deciliter [mg/dL])</p> <p>70 - 120 = 0 (zero) units;</p> <p>121 -150 = 1 unit;</p> <p>151 - 200 = 2 units;</p> <p>(continued on next page)</p>

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 10/31/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>201 - 250 = 3 units;</p> <p>251 - 300 = 4 units;</p> <p>301 - 350 = 6 units;</p> <p>351 - 400 = 8 units</p> <p>401 or greater call provider for dosing. Inject subcutaneously (SC, injection is given in the fatty tissue, just under the skin) before meals and at bedtime for hyperglycemia.</p> <p>During a concurrent observation and interview on 10/29/2024, at 10:50 AM, with Licensed Vocation Nurse (LVN) 3, on Nursing Station 2A at Medication Cart (MedCart) 2A, LVN 3 checked Resident 36's BS level and stated the resident's BS was 122 and required one (1) unit of Humulin R insulin per sliding scale dosing. LVN 3 injected 1U of Humulin R into Resident 36 left upper arm.</p> <p>During an interview on 10/29/2024 at 1:45 PM, with LVN 3, LVN 3 stated Resident 36's GT feeding was disconnected that day, on 10/29/2024 at 9 AM upon completion of the feeding and supposed to be started again at 1 PM. LVN 3 stated that Resident 36 was not ready for the GT feeding to be restarted because the resident wanted to visit with family outside. LVN 3 was not aware of the physician's order to administer Resident 36's Humulin R insulin before a meal.</p> <p>During a concurrent interview and record review with Registered Nurse (RN) 1, on 10/29/2024 at 2:05 PM, Resident 36's physician orders for Humulin R dated 10/7/2024 was reviewed. The order indicated to give before meals and at bedtime. RN 1 stated that Resident 36's GT feeding was turned off daily at 9 AM and turned back on at 1 PM daily. RN 1 stated that Resident 36's order needed to be clarified because the physician ordered the resident's Humulin R to be administered before a meal. RN 1 stated Resident GT feeding was started daily at 1 PM and turned off the next day at 9 AM.</p> <p>During an interview on 10/29/2024 at 2:38 PM, with RN 1, RN 1 stated there was no documentation that Resident 36's physician was notified that the resident was administered Humulin R insulin while the GT feeding was turned off daily between 9 AM to 1 PM. RN 1 stated there was no documentation that Resident 36's Humulin R scheduled for 11:30 AM administration was held, and the physician was called to clarify the order.</p> <p>During an interview on 10/29/2024 at 2:44 PM, with LVN 3, LVN 3 stated, that he had not notified Resident 36's physician that there was a gap between the scheduled administration time of Humulin R insulin scheduled for 11:30 AM administration on 10/29/2024, and the GT feeding being off between 9 AM to 1 PM. LVN 3 stated Resident 36's order for Humulin R scheduled for 11:30 AM administration was not clarified. LVN 3 stated he would have to contact Resident 36's physician to see if the physician wanted to continue to give Humulin R while the GT feeding was off or without a meal.</p> <p>During a record review of Resident 36's Medication Administration Record (MAR, a written record of all medications given to a resident) for the Month of October 2024, the MAR for Resident 36 indicated the resident was administered Humulin R scheduled for 11:30 AM administration 20 times between 10/8/2024 through 10/29/2024 while the GT feeding was turned off which was not in accordance with the physician's order or the manufacturer specification to administer before a meal. Resident 36 was administered Humulin R scheduled for 11:30 AM daily as follows on:</p> <p>(continued on next page)</p>		

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 10/31/2024
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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>10/8/2024 - injected 3 units.</p> <p>10/9/2024 - injected 3 units.</p> <p>10/10/2024 - injected 4 units.</p> <p>10/11/2024 - injected 4 units.</p> <p>10/12/2024 - injected 4 units .</p> <p>10/13/2024 - injected 4 units.</p> <p>10/14/2024 - injected 3 units.</p> <p>10/15/2024 - injected 6 units.</p> <p>10/16/2024 - injected 3 units.</p> <p>10/17/2024 - injected 4 units.</p> <p>10/18/2024 - injected 4 units.</p> <p>10/19/2024 - injected 2 units.</p> <p>10/20/2024 - injected 4 units.</p> <p>10/21/2024 - injected 2 units.</p> <p>10/22/2024 - injected 2 units.</p> <p>10/23/2024 - injected 3 units.</p> <p>10/25/2024 - injected 4 units.</p> <p>10/27/2024 - injected 3 units.</p> <p>10/28/2024 - injected 2 units.</p> <p>10/29/2024 - injected 1 unit.</p> <p>According to manufacturer's labeling for Humulin R dated 6/2023, the manufacturer's labeling indicated, Inject HUMULIN R subcutaneously approximately 30 minutes before meals into the thigh, upper arm, abdomen, or buttocks . Dosage adjustments may be needed with changes in physical activity, changes in meal patterns (e.g., macronutrient content or timing of food intake) . Hypoglycemia is the most common adverse reaction of all insulins, including HUMULIN R. Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life threatening or cause death . Other factors which may increase the risk of hypoglycemia include changes in meal pattern .</p> <p>(continued on next page)</p>

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 10/31/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 55's Admission Record, the admission record indicated Resident 55 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 55's diagnoses included Type II diabetes mellitus with diabetic neuropathy (a condition where there is damage to the nerves), hypertension, and difficulty walking.</p> <p>During a review of Resident 55's MDS, dated [DATE], the MDS indicated Resident 55's cognitive skills for daily decisions making was intact.</p> <p>During a review of Resident 55's care plan focus indicated, The resident has Diabetes Mellitus .care plan, dated 4/1/2024. Resident 55's care plan goals included the resident will be free from any signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar), and have no complications related to diabetes. Staff interventions included diabetes medication as ordered by doctor, monitor and document for side effects and effectiveness, dietary consult for nutritional regimen, and ongoing monitoring.</p> <p>During a review of Resident 55's Order Summary Report, included the following orders:</p> <p>1. Monitor blood sugar AC (before meal) meals, notify MD if blood sugar is greater than 250 before meals for DM, order dated 5/11/2024</p> <p>2. Insulin Aspart (insulin, a hormone that removes excess sugar from the blood) Injection Solution (Insulin Aspart) Inject as per sliding scale: if BS</p> <p>70 -149 = 0 unit;</p> <p>150 -199 = 2 units;</p> <p>200 - 249 = 4 units;</p> <p>250 - 299 = 6 units;</p> <p>300 - 349 = 8 units;</p> <p>350 - 400 = 10 units</p> <p>Call MD if bs is less than (<) 70 and greater than (>) 401, subcutaneously before meals and at bedtime for DM if BS <70 conscious give orange juice, if BS <70 Unconscious give Glucagon 1 mg intramuscularly (IM) and recheck after 15 mins and call MD if BS >400.</p> <p>During a record review of Resident 55's MAR for the Month of October 2024, the MAR for Resident 55 indicated the resident was ordered Insulin Aspart to be administered by SC injection per sliding scale four times a day before meals and at bedtime for, scheduled administration times 6:30 AM, 11:30 AM, 4:30 PM, and 9 PM daily. Licensed nurses documented administration of Insulin Aspart scheduled for 11:30 AM administration was administered five times between 10/25/2024 through 10/29/2024 as follow, on:</p> <p>10/25/2024 - injected 6 units.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>10/26/2024 - injected 2 units.</p> <p>10/27/2024 - injected 4 units.</p> <p>10/29/2024 - injected 2 units.</p> <p>10/30/2024 - injected 2 units.</p> <p>During a concurrent observation and interview on 10/29/2024, at 11:05 AM, with LVN 3, on Nursing Station 2A at MedCart 2A, LVN 3 checked Resident 55's BS level and stated the resident's BS was 176 and required two (2) units of Insulin Aspart per sliding scale dosing. LVN 3 stated the Insulin Aspart Pen was new and needed to be primed before the first use. LVN 3 dialed up 3 units of Insulin Aspart, stated that he ejected 1 unit of Insulin Aspart to prime the new insulin pen and used the remaining 2 units of Insulin Aspart to inject into Resident 55's upper right arm. There was no meal or snack observed available or offered to Resident 55.</p> <p>During an interview on 10/29/2024 at 11:16 AM, with LVN 3, LVN 3 stated lunch trays for Nursing Station 2A would come out around 12 PM.</p> <p>During an interview on 10/29/2024 at 1:43 AM, with Resident 55, inside of Resident 55's room, Resident 55 stated that he received his lunch that day at 12:30 PM (over an hour after Insulin Aspart injection was observed on 10/29/2024 at 11:05 AM).</p> <p>According to the manufacturer's labeling for Insulin Aspart dated 2/2023, indicated, Inject Insulin Aspart subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks, or upper arm . Dosage adjustments may be needed with changes in physical activity, changes in meal patterns (i.e., macronutrient content or timing of food intake) . During changes to a patient's insulin regimen, increase the frequency of blood glucose monitoring . Hypoglycemia is the most common adverse reaction of all insulins, including Insulin Aspart. Severe hypoglycemia can cause seizures, may lead to unconsciousness, may be life threatening or cause death.</p> <p>During an interview on 10/31/2024 at 12:39 PM, with the Dietary Supervisor (DS), the DS stated that Nursing Station 2 was the last station to receive their meals, usually between 1 PM to 1:15 PM daily. The DS stated that Resident 55 was not on a list to receive snacks between meals.</p> <p>During an interview on 10/31/2024 at 1:09 PM, with the Director of Staff Development (DSD), the DSD reviewed the facility's training checklist and stated there was no insulin training on the checklist for licensed nurses. The DSD stated it was important to make sure insulin (Humulin R and Insulin Aspart) was not given too far from a meal being provided to the resident, because the resident could become hypoglycemic.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/31/2024 at 2:12 PM, with the Regional Nurse Consultant (RNC), the RNC stated Humulin R and Insulin Aspart were fast acting insulins. The RNC stated Humulin R and Insulin Aspart should be administered with a meal to prevent the resident from becoming hypoglycemic which could lead to the resident experiencing weakness, dizziness, loss of consciousness, hospitalization , in severe cases the resident could go into a coma or death. The RNC stated Insulin Aspart should be administered within five (5) to 10 minutes of a meal. The RNC if there was a long delay over an hour before receiving a meal after the administration of Insulin Aspart injection could lead to hypoglycemia. The RNC stated the orders for Resident 36 and Resident 55 should have been clarified to make sure the meals and the insulin injections correlated to avoid hypoglycemic episodes.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Timely Administration of Insulin, dated 12/2022, the P&P indicated, It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. All insulins will be administered in accordance with physician orders . Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order.</p>		

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 10/31/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>31333</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications and biologicals were properly stored and labeled for five of five residents (Resident 15, Resident 42, Resident 2, Resident 17, and Resident 92). The facility failed to:</p> <p>A. Ensure one unopened, unused vial of Insulin Lispro was refrigerated until opened or labeled with the date first stored at room temperature inside of Medication Cart (MedCart) 2 labeled for Resident 2</p> <p>B. Ensure one vial of expired Humulin R was removed and discarded and not stored available for use in MedCart 2 labeled for Resident 17</p> <p>C. Ensure controlled [high abuse potential] medications, Lorazepam Oral Solution (a psychotropic medication which act on the brain and nerves to produce a calming effect) requiring refrigeration were stored according to the manufacturer's requirements affecting Resident 15 and Resident 42.</p> <p>D. Ensure one oral inhaler, TRELEGY ELLIPTA (is indicated for the maintenance treatment of patients with chronic obstructive pulmonary disease [COPD]) was dated with an open date and was labeled for Resident 92.</p> <p>E. Ensure discontinued and expired non-controlled medications was destroyed in accordance with the facility's policy and procedures (P&P) titled, Destruction of Unused Drugs.</p> <p>These deficient practices of failing to store or label medications per the manufacturers' requirements increased the risk that Resident 15, Resident 42, Resident 2, Resident 17, and Resident 92 could or have received medication that had become ineffective or toxic due to improper storage or labeling possibly leading to health complications resulting in hospitalization or death.</p> <p>Findings:</p> <p>During a concurrent interview and medication cart inspection on 10/30/2024 at 3:53 PM with Registered Nurse (RN) 2, RN 2 opened MedCart 1A located on Nursing Station 1 and the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications.</p> <p>a. One vial of Insulin Lispro (Brand names, Admelog and Humalog) labeled for Resident 2 was unopened and observed unrefrigerated. RN 2 stated, unopened insulin should have been stored in the refrigerator until opened.</p> <p>According to manufacturer's labeling, Insulin Lispro (Brand Names: Admelog and Humalog), After opening, store at room temperature. Throw away any part not used after 28 days.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. One vial of Humulin R labeled for Resident 17 with an open date of 9/28/2024, was available for use after expiration. RN 2 stated Resident 17's Humulin was expired.</p> <p>According to manufacturer's labeling Humulin R that has been opened is good for 31 days after opening, as long as it is kept refrigerated or at room temperature (up to 86 degrees [] Fahrenheit [F] a temperature scale)</p> <p>c. Two bottles of unrefrigerated Lorazepam Oral Concentrate 2 mg per milliliter (ml, measure of volume) observed inside the locked compartment of MedCart 1A on Nursing Station 1. A refrigerate sticker was placed on the outside packaging of the Lorazepam Oral Concentrate, one box labeled for Resident 15 and the other box labeled for Resident 42. RN 2 reviewed the manufacturer's package insert for lorazepam oral concentrate and stated that she was not aware the medication must be kept refrigerated after opening.</p> <p>According to manufacturer's product labeling, Lorazepam Oral Solution 2 mg/ml should, Store at Cold Temperature - Refrigerate 2 degrees () C (Celsius [a scale of temperature] to 8 C (36 F (Fahrenheit [a scale of temperature] to 46 F) and discard 90 days after opening.</p> <p>d. During a concurrent interview and medication cart inspection on 10/30/2024 at 4:41 PM with Licensed Vocational Nurse (LVN) 8, MedCart 2B located on Station 2 was inspected and one oral inhaler, Trelegy Ellipta (a combination of three long-acting medications that work together to help improve breathing) 200 micrograms (mcg, measure of weight) per 62.5 mcg/25 mcg, was observed opened with no open date. LVN 8 stated he was not aware of the shortened expiration date once the Trelegy Ellipta inhaler was opened for Resident 92.</p> <p>According to manufacturer's package labeling indicated, TRELEGY ELLIPTA should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard TRELEGY ELLIPTA 6 weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first. The inhaler is not reusable. Do not attempt to take the inhaler apart.</p> <p>e. During a concurrent interview and medication area inspection on 10/30/2024 at 12:30 PM, with LVN 6, Nursing Station 2 Medication Storage Room was inspected. LVN 6 provided the non-controlled disposition binder and stated the night shift licensed nurses dispose of the discontinued and expired medications. LVN 6 stated non-controlled medications were disposed of by one nurse sometimes. LVN 6 stated the non-controlled destruction binder dated between 5/2024 through 9/2024 documented one nurse's initial and the space for witness was left blank, no initial or signature.</p> <p>During an interview on 10/30/2024 at 4:56 PM, with LVN 8, LVN 8 stated that he disposed of non-controlled medications, documented the disposal in a binder and disposed of the medications without a witness. LVN 8 stated a second nurse or witness was not needed when disposing of non-controlled medications.</p> <p>During an interview on 10/31/2024 at 2:33 PM, with the Regional Nurse Consultant (RNC), the RNC stated that non-controlled medication destruction should be done by a licensed nurse and with a witness. The RNC stated the witness was to ensure that the medications were being destroyed properly.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Medication Storage, revised 12/2022, the P&P indicated, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature . All drugs and biological will be store in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls . All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. Temperatures are maintained within 36-46 degrees F .</p> <p>During a review of the facility's P&P titled, Destruction of Unused Drugs, revised 8/2023, the P&P indicated, All unused, contaminated, or expired prescription drugs shall be disposed of in accordance with state laws and regulations (refer to any state-specific requirements) .A destruction record must be maintained for all drugs destroyed. The actual destruction of drugs conducted by our facility must be witnessed by facility staff as per state requirements .</p>		

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 10/31/2024
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48131</p> <p>Based on observation, interview, and record review, the facility failed to offer alternative food choices and provide an alternative menu for two of eight sampled residents (Residents 24 and 77).</p> <p>This deficient practice had the potential to impact Resident's 24 and 77 nutritional status, quality of life and result in food dissatisfaction leading to insufficient food intake.</p> <p>Findings:</p> <p>a. During a review of Resident 77's Admission Record, dated 10/31/2024, the admission record indicated Resident 77 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 77's diagnoses included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), dysphagia (difficulty swallowing), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and hyperlipidemia (an abnormally high amount of fat in the blood).</p> <p>During a review of Resident 77's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 7/23/2024, the MDS indicated Resident 77 was cognitively intact (the ability to think, remember and reason). The MDS indicated Resident 77 had the ability to eat independently and a helper was needed to assist with set-up and clean up.</p> <p>During a review of Resident 77's History and Physical (H&P), dated 11/1/2023, the H&P indicated Resident 77 was able to make her own medical decisions.</p> <p>During a review of Resident 77's Nutritional Assessment on 11/9/2023, the nutritional assessment indicated Resident 77's blood sugar levels were well-managed and a liberalized diet (allows individuals to eat a regular diet that includes foods they enjoy, potentially leading to improved nutritional intake) was appropriate.</p> <p>During a review of Resident 77's care plan with a focus on nutritional problems or potential nutritional problems, initiated on 8/1/2024 and revised on 10/24/2024, the care plan indicated Resident 77's would maintain adequate nutritional status by maintaining weight and consuming at least 50-75 percent (%) of at least two meals daily. The care plan indicated interventions were to honor Resident 77's food preferences within diet parameters and offer substitute if meals were less than 50%.</p> <p>During a review of Resident 77's Order Summary Report, dated 10/31/2024, the order summary report indicated an active order on 4/19/2024 of a health shake one time a day for supplement at breakfast.</p> <p>During a review of Resident 77's Order Summary Report, dated 10/31/2024, the order summary report indicated an active order dated 9/16/2024 for a regular textured diet with controlled carbohydrates (sugars and starches), thin consistency with fortified (foods that have additional nutrients added to them) cereal at breakfast, fortified soup in mug for lunch and dinner for nutrition.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 77's Tray Ticket (the ticket on the food tray from the kitchen that details the specific food items a resident should receive based on their dietary needs and meal selections) on 10/31/2024 at 8:07 a.m., the tray ticket indicated Resident 77's preferences were eggs and yogurt.</p> <p>b. During a review of Resident 24's Admission Record, dated 11/5/2024, the admission record indicated Resident 24 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 24's diagnoses included congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hyperlipidemia (high levels of fat in the blood), hypertension (HTN- high blood pressure), gastroesophageal reflux disease (GERD - a chronic condition that occurs when stomach contents leak back into the food pipe), and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24's cognition was severely impaired. The MDS indicated Resident 24 had the ability express ideas and wants and could understand with clear comprehension. The MDS indicated Resident 24 required assistance with eating by providing verbal cues, touching, and steadying to complete the activity. The MDS indicated Resident 24 was receiving a mechanically altered diet (change in texture of food or liquids) and that it was somewhat important to Resident 24 to have snacks available between meals.</p> <p>During a review of Resident 24's H&P, dated 10/17/2024, the H&P indicated Resident 24 did not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 24's care plan with a focus on nutritional problems or potential nutritional problems, initiated on 10/19/2023 with the last revision on 10/22/2024, the care plan indicated Resident 24's oral intake would be greater than 75% to meet estimated needs. The care plan indicated interventions indicated to honor Resident 24's food preferences within diet parameters and offer substitute if meals were less than 50%.</p> <p>During a review of Resident 24's Order Summary Report, dated 11/5/2024, the order summary report indicated an active order dated 11/6/2022 for a snack in between meals three times a day for nourishment.</p> <p>During a review of Resident 24's Order Summary Report, dated 11/5/2024, the order summary report indicated an active order dated 9/16/2024 for a regular diet with soft and bite sized texture, thin consistency, fortified three times a day, and moistened soft bread with no hard crust.</p> <p>During a review of Resident 24's Order Summary Report, dated 11/5/2024, the order summary report indicated an active order dated 10/23/2024 for a health shake one time a day for weight gain.</p> <p>During a review of Resident 24's Tray Ticket on 10/31/2024 at 8:08 a.m., the tray ticket indicated Resident 24 preferences were an English muffin and fresh fruit.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 10/30/2024 at 1:17 p.m. with Resident 77 and Resident 24, in Resident 77 and 24's room, observed Resident 77's meal tray. Resident 77 lunch tray consisted of vegetable lasagna, squash, and a bread stick with a cup of canned peaches and soup on the side. Resident 77 stated she did not like her lunch meal for that day or the day before. Resident 77 stated she wanted something else because she did not know what she was eating. Resident 77 stated she did not inform the nurse because she did not feel it would do any good. Resident 77 stated she was never offered an alternative meal choice. Resident 77's roommate (Resident 24) stated she was having the same issue with the food. Resident 24 stated, The food is terrible, I don't know what I'm eating! Resident 24 stated the food was tasteless and she refused to eat it. Resident 24's tray was untouched, and she was eating from a large container of cashews.</p> <p>During a concurrent observation and interview on 10/31/2024 at 7:51 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated in general a resident could be given an alternative menu if the resident did not like their food. CNA 2 stated residents could retrieve an alternative menu from the hallway to choose an alternative meal. CNA 2 walked down the hall and pointed to the area where the alternative menus were displayed. CNA 2 stated both Resident 77 and Resident 24 could get a menu from this area in the hallway.</p> <p>During a concurrent observation and interview on 10/31/2024 at 7:58 a.m., with CNA 2, Resident 77 and Resident 24, Residents 77 and 24 were both shown the alternative menu located down the hall and posted on the wall in the hallway. Resident 24 and Resident 77 were both asked if they had ever been given this menu to choose alternatives if they did not like their meals. Resident 24 and Resident 77 both stated they had never seen the alternative menu before.</p> <p>During an interview on 10/31/2024 at 8:00 a.m., with CNA 4, CNA 4 stated she was Resident 24's assigned nurse. CNA 4 stated she was not Resident 24's nurse the day prior (10/30/2024), but if Resident 24 did not like her food, she should have been offered something else to eat. CNA 4 stated residents need to have something they like to eat so that they have energy to do what they need to do such as therapy and activities. CNA4 stated if the resident did not eat their meals, they would get weaker.</p> <p>During an interview on 10/31/2024 at 12:09 p.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 stated when residents do not like the food offered, they should be given alternative options. LVN 5 stated CNAs were supposed to report to the charge nurse if residents were not eating or did not like their meals. LVN 5 stated, if a resident did not like a meal, the nurses could find out what the resident liked and go to the kitchen to have it made for the resident. LVN 5 stated she was never informed by the CNAs Resident 24 and Resident 77 disliked their food. LVN 5 stated Resident 24 and Resident 77 should have been offered an alternative menu and the residents should not have to retrieve the menu from the hall. LVN 5 stated if the resident tells staff they did not like the meal, the CNAs should get them an alternative menu and ask the resident if they would like an alternative meal. LVN 5 stated if it was known that Resident 24 and 77 did not like their meals, the dietary manager could have come by to see the residents and figure out what type of food the residents preferred. LVN 5 stated when residents did not get what they want to eat, the residents may stop eating, lose weight and become malnourished.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/28/2024 at 11:24 a.m., with Resident 77, Resident 77 stated the food was terrible and the facility keeps serving the same foods. Resident 77 stated the nurses did not offer an alternative. Resident 77 stated when she did not eat her meal, the nurses would take the tray away without asking the resident why she did not eat.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Initial Resident Visitation/Nutritional Screening, dated 2016, the P&P indicated designated staff should visit each resident within 72 hours or in the first week following admission and complete a dietary interview and prescreen. The P&P indicated residents would be provided a suitable nourishing alternate meal after planned, served meal had been refused. The P&P indicated nursing personnel would ask any resident who does not eat his meal or food item as to why he did not eat and offer a food substitution in accordance with the resident's diet order.</p> <p>During a review of the facility's P&P titled, Meal Hours, revised 7/2/2018, the P&P indicated, Residents' needs, preferences, requests for meal and snack times should be met and care planned.</p> <p>During a review of the facility's P&P titled, Promoting/Maintaining/ Resident Dignity, revised 12/19/2024, the P&P indicated, during interactions residents, staff must report, document and act upon information regarding resident preferences.</p>		

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 10/31/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47679</p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary food storage practice was upheld in the kitchen when:</p> <ol style="list-style-type: none"> 1. The temperature for Refrigerator 1 was not logged for two days. 2. A container of grated cheese was not labeled with the item name, open date, and the use by date. 3. An open bag of tortillas was ripped and was not placed in a tight-lidded container after opening. <p>These deficient practices had the potential to result in harmful bacteria growth and cross contamination (unintentional transfer of harmful bacteria) that could lead to foodborne illness in residents that received food from the kitchen.</p> <p>Findings:</p> <p>a. During a concurrent interview and record review during the initial kitchen tour on [DATE] at 8:43 a.m., with the Dietary Supervisor (DS), the Record of Refrigeration Temperature for Refrigerator 1, for [DATE] was reviewed. The Record of Refrigeration Temperature did not have a temperature and staff initials indicated for [DATE] and [DATE]. The DS stated the refrigerator temperatures were to be checked every day and there was no documentation to show the temperature for Refrigerator 1 was checked on [DATE] and [DATE].</p> <p>During an interview on [DATE] at 10:47 a.m., with the DS, the DS stated the temperature of the refrigerators and freezer were checked first thing in the morning to ensure they were working properly at the correct temperature. The DS stated checking the temperatures would allow the facility to fix any problems with the system. The DS stated if the temperature was not logged on the sheet, they would be unaware of any issues with the system and if the temperatures of the refrigerator was outside of the acceptable ranges, the produce inside could go bad.</p> <p>b. During a concurrent observation and interview during the initial kitchen tour on [DATE] at 8:44 a.m., with the DS, inside Refrigerator 2, a container of grated cheese was observed not labeled with the product name, open date, and use by date. The DS stated the grated cheese was transferred into the container and was not properly labeled.</p> <p>During an interview on [DATE] at 10:49 a.m., with the DS, the DS stated when a food item was placed into a different container, the container had to be labeled with the name of the food item, the date it was opened, and the best by date. The DS stated appropriately labeling food containers would prevent any confusion of what the food item in the container was. The DS stated it was important to label the container with the open and use by dates to ensure the product was not used past the use by date. The DS stated being unaware of the use by date placed the risk of using an expired food product that could harbor bacteria and could make the residents sick if consumed.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. During a concurrent observation and interview during the initial kitchen tour on [DATE] at 8:48 a.m., with the DS, an opened bag of tortillas was observed on the bread shelf. The bag of tortillas was ripped on the side. The DS stated the bag of tortillas should be discarded and should have been stored in an additional container.</p> <p>During an interview on [DATE] at 10:51 a.m., with the DS, the DS stated after opening any food item that could not be sealed, that food item had to be placed into a sealable container to avoid contamination. The DS stated the tortilla bag was ripped and that placed the food at an additional risk of bacteria entering the bag and contaminating the food. The DS stated if the tortillas were to be contaminated with bacteria and was served to the residents, they were at risk of getting sick.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Record of Refrigeration Temperatures, revised [DATE], the P&P indicated, A daily temperature record is to be kept of refrigerated items.</p> <p>During a review of the facility's P&P titled, Food Storage, revised [DATE], the P&P indicated when not obvious what the food or beverage product was, the product must be labeled and dated. The P&P indicated any open products should be placed in [a] seamless plastic or glass containers with tight-fitted lids and labeled and dated.</p> <p>During a review of the facility's P&P titled, Date Marking for Food Safety, revised [DATE], the P&P indicated food should be clearly marked to indicate the date or date by which the food shall be consumed or discarded.</p>		

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 10/31/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31333</p> <p>Based on observation, interview, and record review the facility failed to implement infection control practices for six of six residents (Resident 5, 54, 76, 281, 8, and 92) when the following occurred:</p> <ol style="list-style-type: none"> 1. Licensed nurses did not wear appropriate personal protective equipment (PPE, equipment worn for protection against infectious materials, e.g. gown and gloves) during the handling of a gastrostomy tube (G-tube, tube inserted through the abdomen that delivers nutrition, hydration, and/or medication directly to the stomach) and during direct resident contact during medication administration to Resident 81. 2. Resident 54's nasal cannula tubing (a plastic medical device to provide supplemental oxygen therapy to people who had lower oxygen levels, device goes directly into the nostrils) was touching the floor. 3. Resident 76's indwelling urinary catheter (a thin, hollow tube that's inserted into the bladder to drain urine) tubing was touching the floor. 4. Resident 281's indwelling urinary catheter tubing was touching the floor. 5. Resident 92's oxygen humidifier bottle (used to decrease drying out of the upper respiratory tract during long term oxygen use) was not labeled. 6. Resident 5's bed linens observed on the floor were placed back on Resident 5's bed. <p>These deficient practices placed Resident 81, 54, 76, 281, 92, and 5 at risk for infections which could increase the morbidity (the amount of disease in a population) and mortality (the state of being subject to death) among the residents and all the other residents residing in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 81's Admission Record, the admission record indicated Resident 81 was admitted to the facility on [DATE]. Resident 81's diagnoses included hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (mild or partial weakness or loss of strength on one side of the body) following cerebral infarction (stroke, when blood flow to the brain was blocked) affecting the left non-dominant side, dysphagia (difficulty swallowing) and encounter for attention to G-tube. <p>During a review of Resident 81's care plan focus indicated, The Resident on Enhanced Barrier Precautions related to (r/t) presence of Foley (indwelling) catheter, Gastrostomy tube, Perma- Catheter, PICC Line, Central Line or Non-healing wound, dated 4/25/2024 and revised 7/2/2024. The goal indicated to minimize the risk of infection spreading. The staff intervention's indicated to not wear the same gown and gloves for the care of more than one person, post signage at entrance of the resident's room, wear gloves and gown for High Contact resident care activities, device care or use of the gastrostomy tube.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent MedPass observation and interview on 10/29/2024 from 9:12 a.m. to 10:00 a.m. with Licensed Vocational Nurse (LVN) 1 on Nursing Station and Medication Cart (MedCart) 1A, LVN 1 prepared Resident 81's morning medications with a 9 a.m. administration time. A sign was posted outside of Resident 81's room that indicated, STOP Enhanced Barrier Precautions STOP, the sign indicated staff was to wear gloves and gowns when providing resident care. LVN 1 stated the sign outside of Resident 81's door that indicated Enhanced Barrier Precautions, was for Resident 81's roommate and that Resident 81 was not under any precautions. LVN 1 sanitized her hands, put on a pair of gloves, and entered Resident 81's room without putting on a gown. LVN 1 touched Resident 81's stomach, G-tube, and tubing to check G-tube placement, G-tube residual (a procedure that determines how much fluid is left in the stomach after a feeding), and then administered seven different medications through the G-tube to the resident.</p> <p>During an interview on 10/30/24 at 10:48 AM, with LVN 6, LVN 6 stated the signs outside of the resident's rooms that indicate, Enhanced Barrier Precautions were for residents that have G-tubes, catheters, wounds, urinary tract infections (UTI was a common infection that occurs when bacteria entered the urinary tract and multiplied), or other infections and was for infection control. LVN 6 stated the nurses must sanitize their hands, put on gowns, gloves, and masks before entering the resident's room and sanitize their hands when exiting the resident's room.</p> <p>During an interview on 10/31/2024 at 8:51 a.m., with the Infection Preventionist Nurse (IPN), IPN stated the Enhanced Barrier Precautions signs posted outside of the resident's rooms were indicated for licensed nurses to gown up as an extra precaution. IPN stated a gown should be worn by licensed nurses during medication administration to residents receiving medications through a G-tube to avoid any transmission of infection to other residents and staff.</p> <p>During an interview on 10/31/2024 at 12:45 p.m., with the Director of Staff Development (DSD), the DSD stated with Enhanced Barrier Precautions, includes wearing a gown because the nurses were providing direct care to the resident during G-tube medication administration.</p> <p>During an interview on 10/31/2024 at 2:35 p.m., with the Regional Nursing Consultant (RNC), the RNC stated the licensed nurse should wear gown, gloves, and a mask for enhanced barrier precautions when administering medication via G-tube because they were having direct contact with the resident.</p> <p>45009</p> <p>2. During an observation on 10/28/2024 at 11:28 a.m., in Resident 54's room, Resident 54's nasal cannula tubing was observed touching the floor.</p> <p>During an observation on 10/29/2024 at 8:11 a.m., in Resident 54's room, Resident 54's nasal cannula tubing was observed touching the floor.</p> <p>During an observation on 10/30/2024 at 10:50 a.m., in Resident 54's room, Resident 54's nasal cannula tubing was observed touching the floor.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 54's Admission Record, the admission record indicated Resident 54 was originally admitted to the facility on [DATE] and readmitted to facility on 12/13/2020. Resident 54's diagnoses included chronic kidney disease (gradual loss of kidney function, kidneys were unable to filter wastes and excess fluids from blood) and cardiomegaly (a condition where the heart became enlarged, or larger than normal).</p> <p>During a review of Resident 54's History and Physical (H&P) dated 4/11/2024, the H&P indicated Resident 54 did not have the capacity to make medical decisions.</p> <p>During a review of Resident 54's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/24/2024, the MDS indicated Resident 54's cognitive skills for daily decision making (ability to think and reason) was severely impaired. The MDS indicated Resident 54 required moderate assistance for oral hygiene and personal hygiene. The MDS indicated Resident 54 was dependent on staff for dressing, toileting hygiene and putting and taking off footwear.</p> <p>During an interview on 10/30/2024 at 2:07 p.m., with the IPN, the IPN stated staff must make sure nasal cannula tubing did not touch the floor to prevent an infection. The IPN stated it was important to follow these infection prevention practices for residents' health.</p> <p>During an interview on 10/31/2024 at 12:40 p.m. with Registered Nurse (RN) 1, RN 1 stated all staff were responsible to make sure the resident's nasal canula tubing did not touch the floor. RN 1 sated staff must monitor the position of the tubing because it was an infection prevention practice. RN 1 stated it was important to practice infection prevention practices because it would decrease the risk for residents getting an infection due to contamination.</p> <p>3. During an observation on 10/28/2024 at 11:24 a.m., in Resident 76's room, Resident 76's indwelling urinary catheter tubing was observed touching the floor.</p> <p>During an observation on 10/29/2024 at 2:01 p.m., in Resident 76's room, Resident 76's indwelling urinary catheter tubing was observed touching the floor.</p> <p>During a review of Resident 76's Admission Record, the admission record indicated Resident 76 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 76's diagnoses included obstructive uropathy (a condition in which the flow of urine was blocked) and dementia (a progressive state of decline in mental abilities).</p> <p>During a review of Resident 76's H&P dated 5/27/2024, the H&P indicated Resident 76 was not able to make financial or medical decisions due to dementia.</p> <p>During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 76 required moderate assistance (helper did less than half the effort) for oral hygiene, upper body dressing and personal hygiene.</p> <p>During an interview on 10/30/2024 at 2:07 p.m., with the IPN, the IPN stated staff must make sure the catheter tubing did not touch the floor to prevent an infection. The IPN stated it was important to follow these infection prevention practices for residents' health.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/31/2024 at 12:40 p.m. with RN 1, RN 1 stated all staff were responsible to make sure catheter tubing did not touch the floor. RN 1 sated staff must monitor the position of the catheter tubing because it was an infection prevention practice. RN 1 stated it was important to practice infection prevention practices because it would decrease the risk for residents getting an infection due to contamination.</p> <p>4. During an observation on 10/28/2024 at 11:37 a.m., in Resident 281's room, Resident 281's indwelling urinary catheter bag was observed uncovered and the catheter tubing was touching the floor.</p> <p>During an observation on 10/29/2024 at 9:11 a.m., in Resident 281's room, Resident 281's indwelling urinary catheter bag was observed uncovered and the catheter tubing was touching the floor.</p> <p>During a review of Resident 281's Admission Record, the admission record indicated Resident 281 was admitted to the facility on [DATE]. Resident 281's diagnoses included obstructive uropathy and respiratory failure (serious condition that made it difficult to breathe on your own, lungs could not get enough oxygen into the blood).</p> <p>During a review of Resident 281's H&P dated 10/25/2024, the H&P indicated Resident 281 did not have any focal, sensory, or motor deficits.</p> <p>During a review of Resident 281's Electronic Medical Record (EMR), the EMR indicated there was no MDS as available due Resident 281's recent admission to the facility.</p> <p>During an interview on 10/30/2024 at 2:07 p.m., with the IPN, the IPN stated staff must make sure the catheter tubing did not touch the floor to prevent an infection. The IPN stated it was important to follow these infection prevention practices for residents' health.</p> <p>49900</p> <p>5. During an observation on 10/28/2024 at 10:07 a.m., at Resident 92's bedside, there was no date observed on the oxygen humidifier bottle.</p> <p>During a concurrent observation and interview on 10/30/2024 at 10:15 a.m., at Resident 92's bedside, with LVN 6, there was no date observed on the oxygen humidifier bottle. LVN 6 stated the oxygen humidifier should be dated because staff needed to change the humidifier every week for infection control purposes. LVN 6 stated no date meant staff did not know when it was changed.</p> <p>During a review of Resident 92's Admission Record, the admission record indicated Resident 92 was originally admitted to facility on 7/12/2024. Resident 92's diagnoses included pulmonary mycobacterial infection (a lung infection caused by bacteria found in soil and water), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), chronic respiratory failure with hypoxia (a serious condition where the lungs were unable to remove enough oxygen from the blood over time), and sepsis (a life-threatening blood infection).</p> <p>During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 92 was receiving continuous oxygen therapy.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 92's order summary report, dated 10/31/2024, the report indicated an order to administer oxygen continuously every shift starting on 9/9/2024.</p> <p>48131</p> <p>6. During a review of Resident 5's Admission Record, dated 10/31/2024, the admission record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included muscle weakness, anxiety disorder (a mental health disorder that produced fear, worry, and a constant feeling of being overwhelmed), dementia, functional quadriplegia (paralysis from the neck down, including legs, and arms without injury to the brain or spinal cord), contracture of right hand (a stiffening/shortening at any joint, that reduced the joint's range of motion), lack of coordination, and anemia (a condition where the body did not have enough healthy red blood cells).</p> <p>During a review of Resident 5's Social Service Assessment, dated 12/22/2022, the social services assessment indicated Resident 5 had no capacity to make decisions.</p> <p>During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 5 had some difficulty communicating words and thoughts but could comprehend most conversation. The MDS indicated Resident 5 was dependent and required the assistance of two or more helpers for eating, toileting, bathing, and personal hygiene. The MDS indicated Resident 5 had impairments on both sides of the lower extremities and to one side of the upper extremity.</p> <p>During a concurrent observation and interview on 10/28/2024 at 12:45 p.m., with Resident 5, in Resident 5's room, observed Resident 5 lying in bed uncovered, with her linens lying on the floor next to the bed. Resident 5 stated that she was cold and requested to be covered up.</p> <p>During a concurrent observation and interview on 10/28/2024 at 12:50 p.m., with Certified Nursing Assistant (CNA) 3, in Resident 5's room, CNA 3 asked Resident 5 if she needed assistance. Resident 5 yelled to CNA 3 that she was cold and wanted to be covered up. CNA 3 picked up the linens from the floor and placed them back onto Resident 5's bed. CNA 3 stated clean linens should have been provided for Resident 5 and the dirty linens from the floor should not have been placed back on the resident because of infection control.</p> <p>During an interview on 10/31/2024 at 12:00 p.m., with LVN 5, LVN 5 stated when linens fall to the floor, they should be replaced with clean linens. Resident 5 should not be covered with dirty linens.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled, Infection and Prevention and Control Program, dated 2/19/2022, the P&P indicated the facility had an infection prevention program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P indicated the laundry and direct care staff should handle, store, process, and transport linens to prevent the spread of infection. The P&P indicated clean linen should be separated from soiled linen at all times, and soiled linen should be collected at bedside and placed in a linen bag. The P&P indicated soiled linen should not be kept in the resident's room or bathroom. The P&P indicated all direct care staff should demonstrate competence in relevant infection control practices.</p> <p>(continued on next page)</p>		

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 10/31/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, Oxygen administration, revised on 5/20/2024, the P&P indicated one of the infection control measures was to change humidifier bottle when empty, weekly or per facility policy.</p> <p>During a review of the facility's P&P titled, Enhanced Barrier Precautions, revision date 6/2024, the P&P indicated Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms . Facility staff will receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions. Facility staff will receive training on high-risk activities and common organisms that require enhanced barrier precautions . The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education .High-contact resident care activities include: . Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes.</p>