

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 W Washington Bl Los Angeles, CA 90018	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<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** 48778</p> <p>Based on interview and record review, for one of three residents ' (Resident 1), the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 1 had an order for oxygen administration. 2. Call the physician for Resident 1, who received oxygen without a physician ' s order and suffered a low oxygen saturation (O2 Sat- [%] measures how much oxygen is in the blood, normal range 95% to 100%) of 79%-81% on 10/2/2024. 3. Provide the treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. <p>This failure resulted in the resident ' s delay in receiving interventions from the physician which could have prevented resident ' s transfer to the general acute care hospital (GACH).</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a brain disorder caused by chemical imbalance in the blood that affects brain function), sepsis (a life-threatening emergency characterized by an extreme response to infection that can result in multi-system organ failure), pneumonitis (inflammation of the walls of the alveoli in the lungs, usually caused by a virus), diabetes mellitus (abnormal blood sugar levels), anemia (low blood count), hypertension (high blood pressure), chronic systolic heart failure (hear failure), bacteremia (presence of bacteria in the blood), kidney failure and adult failure to thrive (a syndrome that describes a state of physical and psychological decline in adults).</p> <p>During a review of Resident 1 ' s order summary report dated 9/27/2024, Resident 1 did not have any orders for oxygen administration or to titrate oxygen.</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 9/28/2024, the H&P was not checked off to indicate Resident 1 ' s capacity (an individual ' s mental or physical ability) to understand and make decisions, or resident ' s incapability (lack of ability) to understand and make decisions. The H&P indicated Resident 1 could make decisions for activities of daily living (ADL).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 10/1/2024, the MDS indicated had impaired cognitive ability. The MDS indicated Resident 1 was dependent with staff with ADLs and mobility.</p> <p>During a review of Resident 1 ' s progress notes dated 10/2/2024 at 5:45 a.m., the notes indicated Resident 1 was congested, suctioned, had an O2 Sat of 78-81% and was on oxygen at two (2) liters per minute (LPM). The notes indicated Licensed Vocational Nurse (LVN) 1 called 911 (medical emergency phone number) and 911 took Resident 1 to a general acute care hospital (GACH) on 10/2/2024.</p> <p>During a concurrent interview and record review on 10/3/2024 at 3:27 p.m. with LVN 1, Resident 1 ' s order summary report was reviewed. LVN 1 stated Resident 1 was received at the start of shift with a continuous flow of 2 liters of oxygen via nasal cannula (a medical device that provides supplemental oxygen to patients through two prongs inserted into their nostrils) on 10/2/2024. LVN 1 verified that Resident 1 ' s physician ' s order did not indicate an order to administer oxygen. LVN 1 stated although Resident 1 had been receiving the oxygen, during the low O2 Sat 79%-81% on 10/2/2024 with the 2 liters of oxygen, the physician should have been called and notified to obtain the oxygen order and other orders, aside from calling the emergency services.</p> <p>During a concurrent interview and record review on 10/4/2024 at 2:44 p.m. with the Director of Nursing (DON), Resident 1 ' s care plan, dated 9/30/2024, and licensed nurse notes dated 10/2/2024 at 5:45 a.m., were reviewed. The DON stated Resident 1 ' s care plan indicated Resident 1 was at risk for respiratory distress (shortness of breath, irregular respiration, wheezing/crackles, rhonchi, activity intolerance, edema). The DON stated, the interventions indicated to inform medical doctor (MD) promptly for shortness of breath, irregular respiration, wheezing, crackles, rhonchi, coughing, weakness, activity intolerance, excessive secretions, to monitor oxygen saturation as needed/ordered and apply oxygen as needed/ordered. The DON stated the licensed nurse notes on 10/2/2024 at 5:45 a.m. did not indicate the MD was notified. The DON stated if a resident ' s O2 sat was 79-81% at 2 liters of oxygen on 10/2/2024, the nurse should have checked the physician ' s order, called the physician for oxygen titration order, aside from the 911 being called. The DON stated that nurse did not follow the interventions indicated in Resident 1 ' s care plan to notify the physician.</p> <p>During a review of facility ' s policy and procedure (P&P) titled, Change in a Resident ' s Condition, date 2/2021, the P&P indicated, the facility must promptly notify the attending physician of the resident ' s changes in medical condition.</p> <p>During a review of facility ' s P&P titled, Oxygen Administration, dated 10/2010, the P&P indicated the facility should verify the physician ' s order prior to oxygen administration.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate clinical records for one out of three sampled residents (Resident 1).</p> <p>This failure resulted in incomplete resident records necessary in providing care to Resident 1.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a brain disorder caused by chemical imbalance in the blood that affects brain function), sepsis (a life-threatening emergency characterized by an extreme response to infection that can result in multi-system organ failure), pneumonitis (inflammation of the walls of the alveoli in the lungs, usually caused by a virus), diabetes mellitus (abnormal blood sugar levels), anemia (low blood count), hypertension (high blood pressure), chronic systolic heart failure (hear failure), bacteremia (presence of bacteria in the blood), kidney failure and adult failure to thrive (a syndrome that describes a state of physical and psychological decline in adults).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 9/28/2024, the H&P was not checked off to indicate Resident 1 ' s capacity (an individual ' s mental or physical ability) to understand and make decisions, or resident ' s incapability (lack of ability) to understand and make decisions. The H&P indicated Resident 1 could make decisions for activities of daily living (ADL).</p> <p>During a review of Resident 1 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 10/1/2024, the MDS indicated had impaired cognitive ability. The MDS indicated Resident 1 was dependent with staff with ADLs and mobility.</p> <p>During a review of Resident 1 ' s licensed nursing progress notes, dated 10/2/2024 at 5:45 a.m., the notes indicated Resident 1 was congested, suctioned, had an O2 Sat of 78-81% and was on oxygen at two (2) liters per minute (LPM). The notes indicated Licensed Vocational Nurse (LVN) 1 called 911 (medical emergency phone number) and 911 took Resident 1 to a general acute care hospital (GACH) on 10/2/2024.</p> <p>During a concurrent interview and record review on 10/3/2024 at 3:27 p.m. with LVN 1, progress notes dated, 10/2/2024 at 5:45 a.m. was reviewed. LVN 1 stated Resident 1 ' s vital signs, such as blood pressure, temperature, respiratory rate, and O2 Sat were obtained on 10/2/2024 at 5:45 a.m. during Resident 1 ' s shortness of breath. LVN 1 stated the vital signs should have been documented in the progress notes for communication and accuracy of Resident 1 ' s records. LVN 1 stated, if the vital signs were not recorded in the clinical records, it would seem like it was not done.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 10/4/2024 at 2:44 p.m. with Director of Nursing (DON), Resident 1 ' s licensed nurse progress notes dated 10/2/2024 at 5:45 a.m. was reviewed. The DON license nurse progress notes on 10/2/2024 at 5:45 a.m. was not complete. The DON stated the documentation should have included the chronology (order) of events when Resident 1 was first observed during the change of condition, the assessment conducted, and interventions provided. The DON stated Resident 1 ' s progress notes on 10/2/2024 at 5:45 a.m. was not thorough (complete) of assessments, interventions including physician notification of the change in condition.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Change in a Resident ' s Condition or Status, dated 2/2021, the P&P indicated, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact Situation, Background, Assessment, and Recommendation ([SBAR] a structured way to communicate to the care team about a resident ' s change in condition) Communication Form. The P&P indicated, the nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical condition or status.</p>		