

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Sunny View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 22445 Cupertino Road Cupertino, CA 95014	

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 - 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** 35386</p> <p>Based on interview and record review, The facility failed to ensure staff promptly reported a significant change in condition to the physician for one of two sampled residents (Resident 1). Staff failed to promptly report a significant change in condition to the physician when Resident 1 showed a reduced level of alertness and Resident 1's Glasgow Coma Scale (a scale used to reliably measure a person's level of consciousness after a brain injury) was 9 out of 15 (where a score of 13 or higher correlates with mild brain injury, a score of 9 to 12 correlates with moderate brain injury, and a score of 8 or less represents severe brain injury).</p> <p>This failure resulted in Resident 1 not being seen promptly by a physician at the time of a change in condition (on [DATE]) and/or to receive an acute care hospital evaluation, and as a result was subsequently not deemed a candidate for any intervention when admitted to an acute care hospital admission on [DATE], due to Resident 1's late presentation. Resident 1 was then placed on comfort care (a type of end-of-life treatment that focuses on providing comfort, quality of life, and dignity instead of extending life), and expired in the acute care hospital on [DATE].</p> <p>FINDINGS:</p> <p>Review of Resident 1's Face Sheet (document that contains a summary of a patient's personal and demographic information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of traumatic subarachnoid hemorrhage (an acute brain injury resulting in swelling in the brain), hemiplegia (severe or complete loss of strength or paralysis on one side of the body) and hemiparesis (mild or partial loss of strength or paralysis on one side of the body) following cerebrovascular accident (commonly referred to as a stroke and also referred to as a CVA in which there is an interruption in the flow of blood to cells in the brain depriving them of oxygen). Resident 1's face sheet further indicated Resident 1's Family Member (FM) was Resident 1's durable power of attorney for healthcare (DPOA, person who has legal authority to make medical decisions for an individual). Resident 1's Face Sheet further indicated Resident 1's code status (type of resuscitation [reviving] interventions [if any] a person would like the healthcare team to perform if their heart stopped beating and/or they stopped breathing) was full code (health care personnel would do everything possible to save your life in a medical emergency).</p> <p>Review of Resident 1's Physical Therapy (PT) Progress Note, dated [DATE], indicated Resident 1 actively participated with skilled interventions and there were no barriers impacting treatment.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Sunny View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 22445 Cupertino Road Cupertino, CA 95014	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's PT Progress Note, dated [DATE], indicated Resident 1 actively participated with skilled therapy interventions and barriers impacting treatment were moderate cognitive (relating to or involving the processes of thinking and reasoning) impairment and increased muscle tone and extensor posturing (also called decerebrate posturing, an abnormal body posture that involves the arms and legs being held straight out, the toes being pointed downward, and the head and neck being arched backward).</p> <p>Review of Resident 1's Occupational Therapy (OT) Progress Note, dated [DATE], indicated therapy treatment was well tolerated and there were no barriers impacting treatment.</p> <p>Review of Resident 1's PT Progress Note, dated [DATE], indicated Resident 1 was observed to be non-verbal and mostly not focusing. PT Progress Note further indicated barriers impacting treatment were decreased attention skills and the nurse on duty was made aware of Resident 1's signs and symptoms.</p> <p>Review of Resident 1's OT Progress Note, dated [DATE], indicated Resident 1 did not tolerate the therapy session and Resident 1's Glasgow coma scale was ,d+[DATE]. OT Progress Note further indicated the nurse on duty was notified.</p> <p>Review of Resident 1's Nurse Progress Note, dated [DATE], indicated occupational therapy (OT) reported Resident 1 scored ,d+[DATE] on the Glasgow Coma Scale. Nurse Progress Note further indicated there was no documentation in Resident 1's clinical record that the physician was notified.</p> <p>Review of Resident 1's Speech Therapy (ST) Progress Note, dated [DATE], indicated Resident 1 had a change in condition per Speech Therapist (ST) observation and the Physical Therapist (PT) and Occupational Therapist (OT) report. ST Progress Note further indicated Resident 1 showed minimal receptiveness and verbalization. The ST Progress Note further indicated Resident 1's response to treatment had noticeably declined. ST Progress Note further indicated that the Speech Therapist recommended imaging (a type of test that makes detailed pictures of areas inside the body) consultation to rule out a Transient Ischemic Attack (TIA, short period of symptoms like those of a stroke) or CVA and consulted with the Charge Nurse regarding Resident 1's status.</p> <p>Review of Resident 1's Nurse Progress Note, dated [DATE], indicated Resident 1 was not communicating with PT and when Resident 1 was asked questions Resident 1 did not respond. There was no documentation in Resident 1's clinical record the physician was notified.</p> <p>Review of Resident 1's PT Progress Note, dated [DATE], indicated Resident 1 was non-verbal with mild to moderate spasticity (stiff or rigid muscles) noted on both of her lower extremities. PT Progress Note further indicated barriers impacting treatment were reduced level of alertness and increasing muscle tone. PT Progress Note further indicated nursing was made aware of Resident 1's signs and symptoms during the Interdisciplinary Team (IDT, a group of healthcare professionals who meet to discuss and plan patient care) Care Conference on [DATE].</p> <p>Review of Resident 1's IDT Care Conference Note, dated [DATE], indicated Resident 1 was not eating, had a lot of global extensor tone (Abnormal muscle tone, muscle tone is the resistance of a muscle to active or passive stretch, or the overall stiffness of the muscle) and limited ability to initiate motor movements (actions of the muscles).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Sunny View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 22445 Cupertino Road Cupertino, CA 95014	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Nurse Progress Note, dated [DATE], indicated Resident 1 was not verbalizing to the nurse and was not following directions during the passing of medication. Nurse Progress Note further indicated Resident 1 was not able to complete the PT session and there was no documentation in Resident 1's clinical record that the physician was notified.</p> <p>Review of Resident 1's Nurse Progress Note, dated [DATE], indicated the physician was notified to see Resident 1 regarding therapy noted Resident 1 was non-verbal and had a Glasgow Coma Scale of , d+[DATE] with extensor posturing (involuntary positioning of the arms when stimulated, a result of a severe brain injury). Progress Note further indicated when Resident 1 was admitted to the skilled nursing facility (SNF) Resident 1 was able to say a few words but was now non-verbal.</p> <p>Review of Resident 1's Physician's Progress Note, dated [DATE], indicated the physician was called to see Resident 1 for new changes. Progress Note indicated Resident 1 had clinically worsened with decreased responsiveness. Progress Note further indicated Resident 1 was no longer verbalizing, had possible new right-sided weakness, was unable to swallow medications and food, and had extensor posturing. Progress Note further indicated Resident 1's attending physician (AP) suspected an extension of the CVA (cerebrovascular accident, major worsening, or deterioration in neurological [relating to the nervous system] status following an initial stroke requiring medical attention). The Progress Note further indicated that Resident 1 was transferred to the emergency department (ED) by ambulance.</p> <p>Review of Resident 1's acute care hospital Emergency Department Progress Note, dated [DATE], indicated Resident 1 had been nonverbal for two days and was brought to the ED for not taking oral medications or talking. ED note further indicated Resident 1 was not following commands or talking with a left gaze preference (an abnormality of gaze that can be observed following an acute cerebral lesion, e.g., stroke) and right arm weakness.</p> <p>Review of Resident 1's acute care hospital History & Physical (H & P) dated, [DATE], indicated Resident 1 had a history of a recent stroke and was hospitalized for six days from [DATE] through [DATE], after falling in her bathroom two days prior at home. At discharge from the acute care hospital on [DATE], to the SNF (skilled nursing facility), Resident 1 was able to follow commands and was talking in complete sentences. Subsequently, Resident 1 was then referred to the ED on [DATE], after her SNF staff noted Resident 1 was more lethargic (sluggish & lacking energy) and no longer speaking, with a left lateral gaze preference. Resident 1 was admitted to the Intensive Care Unit (ICU) for further evaluation and taken for a Computed Tomography Scan (CT, a diagnostic imaging procedure that can show whether you had a stroke). CT results showed worsening subdural stroke (also known as subdural hematoma, occurs when a blood vessel in the space between the skull and the brain [subdural space] is damaged) in addition to ischemic stroke (occurs when a blood clot blocks blood flow in your brain, versus hemorrhagic stroke is when a blood vessel in your brain ruptures). The H & P further indicated Resident 1 was not deemed a candidate for any intervention at the time of admission to the acute care hospital on [DATE] due to Resident 1's late presentation. It further indicated Resident 1's code status was changed to do not resuscitate (DNR, do not resuscitate or do not perform cardiopulmonary resuscitation [CPR, emergency lifesaving procedure] to restart the heart) and do not intubate (DNI, do not insert a breathing tube) due to Resident 1's chance of surviving being very low.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Sunny View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 22445 Cupertino Road Cupertino, CA 95014	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's acute care hospital Hospitalist Progress Note dated, [DATE], indicated Resident 1 was unresponsive and not following commands at time of admission . Resident 1's Hospitalist Progress Note further indicated Resident 1 presented at the SNF with a 2-day history of progressive lethargy and altered level of consciousness and was found to have an acute chronic subdural hemorrhage (a pool of blood between the brain and its outermost covering) upon admission to the acute care hospital.</p> <p>Review of Resident 1's Hospital Discharge Summary, dated [DATE], indicated Resident 1 did not show any neurologic improvement with no potential for any meaningful neurologic recovery after admission and was ultimately placed on comfort care and expired in the acute care hospital on [DATE].</p> <p>Review of Resident 1's Death Certificate indicated: date of death : [DATE] Immediate Cause: COMPLICATIONS OF TRAUMATIC SUBDURAL HEMMORRHAGE and Death Reported to Coroner? Yes.</p> <p>During a telephone interview with Physical Therapist A (PT A), on [DATE] at 2:40 p.m., PT A stated that when she first saw Resident 1 on [DATE], Resident 1 was conversing, coherent and responding appropriately. PT A further stated that when she saw Resident 1 on [DATE], Resident 1 was no longer communicating and functionally Resident 1 was declining with upper extremity extensor posturing (involuntary extension of the upper extremities in response to external stimuli). PT A reported the signs and symptoms to the nurse on duty.</p> <p>During a telephone interview with Speech Therapist B (ST B), on [DATE], at 1:45 p.m., ST B stated that when she saw Resident 1 on [DATE], Resident 1 was non-responsive with a noted drastic decline in condition and she reported the change in condition to the nurse on duty. ST B further stated it is a nursing protocol to notify the doctor of a change in condition.</p> <p>During a telephone interview, on [DATE], at 3:56 p.m., Registered Nurse C (RN C) stated that staff usually let the doctor know if there has been a change in a resident's condition and the doctor will order the resident be transferred out to the hospital for further evaluation or treatment. RN C acknowledged that on [DATE] OT reported Resident 1 scored a ,d+[DATE] on the Glasgow Coma Scale. RN C also stated it was a change in condition. RN C further stated he does not remember if he reported it to the doctor. RN C acknowledged there was no documentation in Resident 1's clinical record that the change in condition was reported to the doctor. RN C further stated the doctor should have been notified.</p> <p>During a telephone interview with the Minimum Data Set Coordinator (MDSC), on [DATE] at 4:25 p.m., MDSC stated she assessed Resident 1 when Resident 1 was admitted to the facility. The MDSC further stated at that time Resident 1 was alert and responsive. The MDSC also stated at the IDT care conference on [DATE], therapy reported Resident 1 had a lot of global extensor tone (rigidity) and the MDSC stated that was a change in condition for Resident 1. The MDSC further stated it was something therapy had noted and first brought to her attention at the time of the IDT care conference. MDSC further stated she was not aware if anyone notified the doctor about the Resident 1's change in condition. The MDSC further stated she also did not notify the doctor and that the doctor should have been notified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Sunny View Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 22445 Cupertino Road Cupertino, CA 95014	
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview, on [DATE] at 11:15 a.m., the director of nursing (DON) stated that when there is a change in a resident's condition, staff usually notify the doctor by text message. The DON further stated that she first became aware of Resident 1's change in condition during the IDT Care Conference on [DATE]. The DON further stated she expected that the MDSC would notify the resident's doctor. DON acknowledged that the doctor was not notified about the Resident 1's change in condition and that the doctor should have been notified.</p> <p>During a telephone interview, on [DATE], at 4:00 p.m., Resident 1's attending physician (AP) stated that when she saw Resident 1 on [DATE], Resident 1 was alert and talking intermittently. The AP further stated she was called to see Resident 1 six days later ([DATE]) and the PT pointed out Resident 1 had gone from a 14 on the Glasgow Coma Scale to a 9, had stopped taking her medications, had extensor posturing and was no longer verbal. The AP further stated she did not think she was notified of a change in condition prior to seeing Resident 1 on [DATE]. The AP further stated she notified Resident 1's FM/DPOA and that Resident 1 had possibly extended her stroke (extension or worsening of a stroke following an initial stroke requiring medical attention). The AP further stated Resident 1's FM/DPOA said to send Resident 1 out to the ER (emergency room) for evaluation.</p> <p>Review of the facility's revised [DATE] policy Change in Resident Condition states that any sudden serious change in a resident's condition manifested by a marked change in physical or mental behavior, will be communicated to the physician with a request for a physician visit promptly and/or acute care evaluation. It further states that the resident/resident's representative will be notified that there has been a change in the resident's condition, and what steps are being taken.</p>		