STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Conv. Hospital	2939 S. Peach Avenue Fresno, CA 93725

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation, interview and record review, the facility failed to ensure the right to be free from misappropriation of resident property for eight of eleven residents (Resident 55, 57, 59, 67, 69, 71, 73, 75) when: 1. For Resident 67, a licensed nurse removed 41 alprazolam (a highly addictive medication used for generalized anxiety disorders, panic disorders and insomnia [inability to sleep]) tablets from the medication cart and did not administer the medication to the Resident or waste (discard) the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. 2. For Resident 59, a licensed nurse removed 25 alprazolam tablets from the medication cart and did not administer the medication to the Resident or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. 3. For Resident 69, a licensed nurse removed 21 tramadol (a highly addictive medication used for moderate to severe pain, short-term pain relief) tablets from the medication cart and did not administer the medication to the Resident or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. 4. For Resident 71, a licensed nurse removed 19 tramadol tablets from the medication cart and did not administer the medication to the Resident or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. 5. For Resident 73, a licensed nurse removed 32 hydrocodone-acetaminophen (a highly addictive medication used for moderate to severe pain, short-term pain relief) tablets from the medication cart and did not administer the medication to the Resident or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. 6. For Resident 75, a licensed nurse removed 112 oxycodone (a highly addictive medication used for moderate to severe pain, short-term pain relief) tablets from the medication cart and did not administer the medication to the Resident or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. For Resident 55, a licensed nurse removed 12 oxycodone (a highly addictive medication used for moderate to severe pain, short-term pain relief tablets from the medication cart and did not administer the medication to the resident or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. 8. For Resident 57, a licensed nurse removed 8 hydrocodone-acetaminophen (a highly addictive medication used for moderate to severe pain, short-term pain relief) tablets from the medication cart and did not administer the medication to the resident, or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration. 9. For Resident 59, a licensed nurse removed 11 tramadol (a highly addictive medication used for moderate to severe pain, short-term pain relief) tablets from the medication cart and did not administer the medication to the resident, or waste the medication in accordance with facility policy and procedure and nursing standards of practice for medication administration These failures resulted in the potential harm of patients not receiving prescribed medications that are considered their property and possible injury or harm. These failures resulted in a system failure to reconcile controlled medications (The process of identifying the most accurate list of all medications that the patient is taking). Findings: 1. During a review of Resident 67's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the face sheet indicated, Resident 67 was admitted to the facility on [DATE] with a diagnosis which included cerebral infarction (a stroke, where an area of the brain dies due to lack of oxygen and nutrients), anxiety disorder (a condition where a person has excessive and persistent feelings of fear, dread, and uneasiness) and bipolar disorder (a mental illness that causes extreme mood swings, along with changes in energy, sleep, thinking, and behavior). During a review of Resident 67's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 67's MDS assessment indicated Resident 67's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 5 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 67 was severely impaired. During a review of Resident 67's Electronic Medical Record (EMAR), dated 9/1/24 to 9/30/24, the EMAR indicated, .Schedule for Sep. 2024 . Start date: 9/10/24 at 8 a.m. [alprazolam-(a highly addictive medication used for generalized anxiety disorders, panic disorders and insomnia [inability to sleep]) Oral Tablet 0.25 mg(milligrams- unit of measurement) Give 2 tablets by mouth three times a day at 8 a.m., 12 p.m., and 4 p.m. , for restlessness as evidenced by repetitive physical movements related to Anxiety Disorder . Start date: 7/22/24 to Discontinue date 9/9/24 at 7:06 p.m. [alprazolam] Oral Tablet 0.25 mg(milligrams- unit of measurement) Give 2 tablets by mouth three times a day at 8 a.m., 3 p.m., and 9 p.m., for restlessness as evidenced by repetitive physical movements related to Anxiety Disorder . The EMAR indicated 6 tablets were given every day by nurses in the month of September. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 10/2/24 at 4:45 p.m., with the Consultant Pharmacist (CP), Resident 67's Alprazolam Inventory Count Sheet (ICS) 1-6, dated 9/4/24 to 9/28/24 was reviewed. The ICS indicated 9/7/24, 9/8/24, 9/14/24, 9/20/24, 9/21/24, 9/24/24 and 9/25/24 had alprazolam pulled from the blister pack that were not accounted for in the EMAR or wasted. The CP stated it appeared Licensed Vocational Nurse (LVN) 1 was the person that removed the alprazolam from the blister pack (individual pack of medication) and there was no record of waste nor administration to Resident 67. The CP stated he matched the signature on the inventory control sheet (ICS) to the EMAR so he knew LVN 1 was the nurse who was responsible for the missing medications. The CP stated LVN 1 appeared to be diverting (an attempt to obtain medications under false pretenses for illegal purpose of reselling the drugs to others) all of these medications. The CP stated the processes in place at the facility were not there to catch a determined thief. The CP stated this would be dangerous for Resident 67 in that their anxiety would not have been treated per the physician order. During a concurrent observation and interview on 10/2/24 at 7:15 p.m., with Resident 67 in his room, Resident 67 was lying in bed, awake. Resident 67 stated he was unaware that he took alprazolam for an anxiety diagnosis. During an interview on 10/3/24 at 10 a.m., with LVN 1, LVN 1 stated he had a lot of patients so he forgot to chart the controlled medications (medications whose use and distribution are tightly controlled because of their abuse potential or risk) in the EMAR. LVN 1 stated he had been working too much and just messed up. During an interview on 10/4/24 at 4:30 p.m., with the Owner/Acting Administrator/Interim Director of Nurses (same person-OA), the OA stated the expectation for nursing staff was to follow the physician orders for medication administration and document in the EMAR it was given. The OA stated for as needed (PRN) medication there should be supporting documentation on why the medication needs to be pulled and charted given in the EMAR. The OA stated that it appeared LVN 1 was deliberately taking the mediations and potentially forging signatures as reported by other staff. The OA stated this put residents at risk to have negative outcomes in terms of behaviors and pain not being controlled. During a concurrent interview and record review on 10/10/24 at 11:30 a.m., with the Assistant Director of Nursing (ADON), Resident 67's Alprazolam ICS 1-6, dated 9/4/24 to 9/28/24 was reviewed. The inventory count sheet (ICS) indicated, 42 alprazolam tablets in total were taken from the medication blister pack (a specific type of packaging used primarily for unit-dose packaging of medications and is stored in the nursing medication cart) and not given to Resident 67 per the EMAR, nor wasted on the ICS. The ADON stated there were a nurses initials that appear to be forged, dates that appear to be changed and multiple dates/times where duplicate doses of alprazolam's were taken out on a single day without being charted in the EMAR. During an interview on 10/10/24 at 3:45 p.m., with the Director of Nursing (DON), the DON stated the medications that were taken by LVN 1 per the ICS and not given to a resident or wasted, are the resident's property. The DON stated she would consider that theft because those medications belong to the individual resident. The DON stated the residents paid for it. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 10/11/24 at 10 a.m., with Registered Nurse (RN) 2, RN 2 stated she was the nurse that gave the alprazolam to Resident 67 on 9/12/24, 9/13/24 and 9/14/24. RN 2 stated someone manipulated the date she wrote on the ICS 3. RN 2 stated there was a darker black pen that changed her dates from 9/13/24 to 9/12/24 and 9/13/24 to 9/14/24. RN 2 stated she already wrote the medication administration dates and times for 9/12/24 on ICS 2. RN 2 stated she did not make this date change and it was forged (make an illegal copy of something, especially to deceive people). During a review of Resident 67 Prescription Summary General [NAME] Information (GI), dated 9/4/24, the GI indicated, .Patient: [Resident 67] . Drug: Alprazolam . Quantity: 120 . Price $11.25 . Charge Account: [name of facility] . Price Type: Third party . Review of professional reference Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention, dated July 2012, (found at https://pmc.ncbi.nlm.nih.gov/articles/PMC3538481/) indicated, .healthcare workers who are diverting drugs from the health care facility workplace pose a risk to their patients, their employers, their co-workers, and themselves. It is essential that all health care institutions have a robust system in place to identify and investigate suspected diversion as rapidly and efficiently as possible and that they implement policies and procedures that enable a standardized and effective response to confirmed diversion. Drug diversion by healthcare workers violates the core value that the needs of the patient come first. Clearly, if we are to optimize our approach to inpatient drug diversion and its consequences, we must look at such diversion not as a victimless act but as a multiple-victim crime . 2. During a review of Resident 59's Face Sheet, the face sheet indicated, Resident 59 was admitted to the facility on [DATE] with a diagnosis which included cerebral infarction (a stroke, where an area of the brain dies due to lack of oxygen and nutrients), anxiety disorder (a condition where a person has excessive and persistent feelings of fear, dread, and uneasiness), major depressive disorder (a serious mental health condition that can affect how a person feels, thinks, and acts) and aphasia (a language disorder that makes it difficult to communicate effectively with others). During a review of Resident 59's Minimum Data Set assessment dated [DATE], Resident 59's MDS assessment indicated Resident 59's BIMS assessment score was 00 out of 15. The BIMS assessment indicated Resident 59 was severely impaired. During a review of Resident 59's Electronic Medical Record (EMAR), dated 9/1/24 to 9/30/24, the EMAR indicated, .Schedule for Sep. 2024 . Start date: 9/1/24 at 8 a.m. [alprazolam-(a highly addictive medication used for generalized anxiety disorders, panic disorders and insomnia [inability to sleep]) Oral Tablet 0.25 mg(milligrams- unit of measurement) Give 2 tablets by mouth two times a day at 8 a.m., and 4 p.m., for restlessness as evidenced by repetitive physical movements related to Anxiety Disorder .Start date: 8/11/24 11:30 a.m., to Discontinue date 10/1/24 at 5:11 p.m. [alprazolam] Oral Tablet 0.25 mg(milligrams- unit of measurement) Give 1 tablets by mouth every 6 hours as needed for restlessness as evidenced by repetitive physical movements related to Anxiety Disorder . Hours: PRN (as-needed) . The EMAR indicated 4 tablets were given every day by nurses in the month of September for the scheduled alprazolam and one tablet was given, 9/18/24 by Licensed Vocational Nurse (LVN) 1, for the PRN dose. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 59's Electronic Medical Record (EMAR), dated 8/1/24 to 8/31/24, the EMAR indicated, .Schedule for Aug. 2024 . Start date: 1/4/24 at 8 a.m. to Discontinue date 8/11/24 at 11:30 a.m., (alprazolam) Oral Tablet 0.25 mg . Give 1 tablet by mouth one time a day at 8 a.m., for restlessness as evidenced by repetitive physical movements related to Anxiety Disorder . Start date: 8/11/24 at 4 p.m. to Discontinue date 9/1/24 at 6:07 a.m., (alprazolam) Oral Tablet 0.25 mg . Give 1 tablet by mouth two times a day at 8 a.m. and 4 p.m., for restlessness as evidenced by repetitive physical movements related to Anxiety Disorder . Start date: 8/11/24 11:30 a.m., to Discontinue date 10/1/24 at 5:11 p.m. (alprazolam) Oral Tablet 0. 25 mg . Give 1 tablets by mouth every 6 hours as needed for restlessness as evidenced by repetitive physical movements related to Anxiety Disorder . Hours: PRN (as-needed) . The EMAR indicated 1 tablet was given every day by nurses in the month of August for the scheduled alprazolam and one tablet was given as needed on 8/11/24, 8/12/24, 8/14/24, 8/15/24, 8/16/24, 8/19/24, 8/21/24, 8/22/24, 8/24/24 and 8/25/24 by LVN 1. During a concurrent interview and record review on 10/2/24 at 4:45 p.m., with the Consultant Pharmacist (CP), Resident 59's Alprazolam Inventory Count Sheet (ICS) 1-8, dated 7/9/24 to 10/3/24 was reviewed. The inventory control sheet (ICS) indicated 8/17/24, 8/18/24, 8/23/24, 8/25/24, 8/26/24, 8/27/24, 8/28/24, 9/14/24, 9/18/24, 9/21/24, 9/23/24, 9/24/24 and undated, alprazolam pulled from the blister pack that were not accounted for in the EMAR or wasted. The CP stated it appeared Licensed Vocational Nurse (LVN) 1 was the person that removed the alprazolam from the blister pack and there was no record of waste nor administration to Resident 59. The CP stated he matched the signature on the ICS to the EMAR so he knew LVN 1 was the nurse who was responsible for the missing medications. The CP stated LVN 1 appeared to be diverting all of these medications. The CP stated the processes in place at the facility were not there to catch a determined thief. The CP stated this would be dangerous for Resident 59 in that their anxiety would not have been treated per the physician order. During an observation on 10/2/24 at 6:40 p.m., in Resident 59's room, Resident 59 had only a blank stare and did not respond to any greeting or questions. During a concurrent interview and record review on 10/3/24 at 9:30 a.m., with the Assistant Director of Nursing (ADON), Resident 59's Alprazolam ICS 1-8, dated 7/9/24 to 10/3/24 was reviewed. The ICS indicated 25 alprazolam tablets in total were taken from the medication blister pack and not given to Resident 59 per the EMAR, nor wasted on the ICS. The ADON stated dates appear to be changed on 9/14/24 to 9/13/24 and multiple dates/times had more alprazolam's pulled from the blister pack than ordered. The ADON stated Resident 59 would not get the therapeutic effect of the medication as intended and this would be a patient safety issue. The ADON stated Resident 59 would not be stabilized without his intended medication. During an interview on 10/3/24 at 10 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he had a lot of patients so he forgot to chart the controlled medications (medications whose use and distribution are tightly controlled because of their abuse potential or risk) in the EMAR. LVN 1 stated he had been working too much and just messed up. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/4/24 at 4:30 p.m., with the Owner/Acting Administrator/Interim DON (same person-OA), the OA stated the expectation for nursing staff was to follow the physician orders for medication administration and document in the EMAR it was given. The OA stated for as needed (PRN) medication there should be supporting documentation on why the medication needs to be pulled, and charted given in the EMAR. The OA stated that it appeared LVN 1 was deliberately taking the medications and potentially forging signatures as reported by other staff. The OA stated this put residents at risk for negative outcomes in terms of behaviors and pain not being controlled. During an interview on 10/10/24 at 3:45 p.m., with the Director of Nursing (DON), the DON stated the medications that were taken by LVN 1 per the ICS and not given to the resident or wasted, are resident property. The DON stated she would consider that theft because those medications belong to the resident. The DON stated the residents paid for it. During a concurrent interview and record review on 10/11/24 at 10 a.m., with Registered Nurse (RN) 2, RN 2 stated she was the nurse that gave the alprazolam to Resident 59 on 9/12/24, 9/13/24 and 9/14/24. RN 2 stated someone manipulated the date she wrote on the ICS 6. RN 2 stated there was a darker black pen that changed her dates from 9/12 to 9/13. RN 2 stated she already wrote the medication administration dates and times for 9/14 on ICS 6. RN 2 stated she did not make this date change and it was forged again, just like [Resident 67]. RN 2 stated LVN 1 did not even work on 9/14/24 to her knowledge, so it would be impossible for him to give those medications to Resident 59 as he said he did on ICS 6. During a review of Time Card Report (TCR), dated 9/1/24 to 9/28/24, the TCR indicated, LVN 1 did not work on 9/14/24. Resident 67 Prescription Summary General [NAME] Information (GI) was requested on 10/10/24, but never received. Review of professional reference Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention, dated July 2012, (found at https://pmc.ncbi.nlm.nih.gov/articles/PMC3538481/) indicated, .healthcare workers who are diverting drugs from the health care facility workplace pose a risk to their patients, their employers, their co-workers, and themselves. It is essential that all health care institutions have a robust system in place to identify and investigate suspected diversion as rapidly and efficiently as possible and that they implement policies and procedures that enable a standardized and effective response to confirmed diversion. Drug diversion by healthcare workers violates the core value that the needs of the patient come first. Clearly, if we are to optimize our approach to inpatient drug diversion and its consequences, we must look at such diversion not as a victimless act but as a multiple-victim crime . 3. During a review of Resident 69's Face Sheet, the face sheet indicated, Resident 69 was admitted to the facility on [DATE] with diagnosis which included type 2 diabetes mellitus (a chronic group disease that occurs when the body can't regulate blood sugar levels), myocardial infarction (heart attack), and chronic pain (pain that persist beyond three months). During a review of Resident 69's Minimum Data Set assessment dated [DATE], Resident 69's MDS assessment indicated Resident 69's BIMS assessment score was 15 out of 15. The BIMS assessment indicated Resident 69 was cognitively intact. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 69's Electronic Medical Record (EMAR), dated 9/1/24 to 9/30/24, the EMAR indicated, .Schedule for Sep. 2024 . Start date: 8/13/24 at 11:45 a.m. Tramadol (a highly addictive medication used for moderate to severe pain, short-term pain relief) Oral Tablet 50 mg. Give 1 tablet by mouth every 8 hours as needed for moderate pain . for severe pain .related too Chronic Pain . Hours: PRN (as needed) . Pain Level (a tool that measures pain levels and helps doctors manage pain, 0 no pain to 10 the worst possible pain) . The EMAR indicated 1 tablet of tramadol was given to Resident 69 by LVN 1 on 9/2/24 at 6:50 a.m. During a concurrent interview and record review on 10/2/24 at 4:45 p.m., with the Consultant Pharmacist (CP), Resident 69's Tramadol Inventory Count Sheet (ICS) 1-3, dated 7/27/24 to 9/24/24 was reviewed. The ICS indicated 9/2/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, 9/19/24, 9/20/24, 9/21/24, 9/22/24 and 9/2424, tramadol was pulled from the blister pack that was not accounted for in the EMAR or wasted. The CP stated it appeared Licensed Vocational Nurse (LVN) 1 was the person that removed the tramadol from the blister pack and there was no record of waste nor administration to Resident 69. The CP stated he matched the signature on the ICS to the EMAR so he knew LVN 1 was the nurse who was responsible for the missing medications. The CP stated LVN 1 appeared to be diverting all of these medications. The CP stated the processes in place at the facility were not there to catch a determined thief. The CP stated this would be dangerous for Resident 69 in that their pain would not have been treated per the physician order. The CP stated LVN 1 did not have any pain assessments that would prompt removal of the as needed (PRN) pain medication. During a concurrent observation and interview on 10/2/24 at 6:55 p.m., with Resident 69 in his room, Resident 69 was lying in bed, awake. Resident 69 stated he always had some pain in his body and took [brand name for acetaminophen (pain medication)] for it, but never tramadol. Resident 69 stated he had not taken tramadol in years. During a concurrent interview and record review on 10/3/24 at 9:30 a.m., with the Assistant Director of Nursing (ADON), Resident 69's Tramadol ICS 1-3, dated 7/27/24 to 9/24/24 was reviewed. The ICS indicated 21 tramadol tablets in total were taken from the medication blister pack and not given to Resident 69 per the EMAR, nor wasted on the ICS. The ADON stated because the tramadol was never administered Resident 69 could have suffered in pain. During an interview on 10/3/24 at 10 a.m., with LVN 1, LVN 1 stated he had a lot of patients so he forgot to chart the controlled medications (medications whose use and distribution are tightly controlled because of their abuse potential or risk) in the EMAR. LVN 1 stated he had been working too much and just messed up. During an interview on 10/4/24 at 4:30 p.m., with the Owner/Acting Administrator/Interim DON (same person-OA), the OA stated the expectation for nursing staff was to follow the physician orders for medication administration and document in the EMAR it was given. The OA stated for PRN medication there should be supporting documentation on why the medication needs to be pulled and charted given in the EMAR. The OA stated that it appeared LVN 1 was deliberately taking the medications and potentially forging signatures as reported by other staff. The OA stated this put residents at risk to have negative outcomes in terms of behaviors and pain not being controlled. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/10/24 at 3:45 p.m., with the Director of Nursing (DON), the DON stated the medications that were taken by LVN 1 per the inventory control sheets (ICS) and not given to the resident or wasted, are resident property. The DON stated she would consider that theft because those medications belong to the resident. The DON stated the residents paid for it. During a review of Resident 69 Prescription Summary General [NAME] Information (GI), dated 7/26/24, the GI indicated, .Patient: [Resident 69] . Drug: Tramadol 50 mg . Quantity: 90 . Acquisition Cost: $2.23 . Charge Account: [facility name and insurance information] . Review of professional reference Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention, dated July 2012, (found at https://pmc.ncbi.nlm.nih.gov/articles/PMC3538481/) indicated, .healthcare workers who are diverting drugs from the health care facility workplace pose a risk to their patients, their employers, their co-workers, and themselves. It is essential that all health care institutions have a robust system in place to identify and investigate suspected diversion as rapidly and efficiently as possible and that they implement policies and procedures that enable a standardized and effective response to confirmed diversion. Drug diversion by healthcare workers violates the core value that the needs of the patient come first. Clearly, if we are to optimize our approach to inpatient drug diversion and its consequences, we must look at such diversion not as a victimless act but as a multiple-victim crime . 4. During a review of Resident 71's Face Sheet, the face sheet indicated, Resident 71 was admitted to the facility on [DATE] with diagnosis which included chronic obstructive pulmonary disease (a lung disease that causes breathing problems by damaging the lungs and narrowing the airway), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to perform simple tasks) and fibromyalgia (a chronic condition that causes widespread pain and tenderness in the body, along with other symptoms). During a review of Resident 71's Minimum Data Set assessment dated [DATE], Resident 71's MDS assessment indicated Resident 71's BIMS assessment score was 10 out of 15. The BIMS assessment indicated Resident 71's cognition was moderately impaired. During a review of Resident 71's Electronic Medical Record (EMAR), dated 9/1/24 to 9/30/24, the EMAR indicated, .Schedule for Sep. 2024 . Start date: 8/6/24 at 2 p.m. tramadol (a highly addictive medication used for moderate to severe pain, short-term pain relief) Oral Tablet 50 mg. Give 1 tablet by mouth every 8 hours as needed for pain . Hours: PRN . Pain Level . The EMAR indicated 1 tablet given by Licensed Vocational Nurse (LVN) 1 on 9/19/24 at 1:20 p.m. for a pain level of 7. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Conv. Hospital	2939 S. Peach Avenue Fresno, CA 93725

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 10/2/24 at 4:45 p.m., with the Consultant Pharmacist (CP), Resident 71's Tramadol Inventory Count Sheet (ICS), dated 8/14/24 to 9/24/24 was reviewed. The ICS indicated 8/14/24, 8/20/24, 8/21/24, 8/26/24, 9/2/24, 9/9/24, 9/10/24, 9/11/24, 9/12/24, 9/19/24, 9/21/24, 9/22/24 and 9/24/24, tramadol was pulled from the blister pack that was not accounted for in the EMAR or wasted. The CP stated it appeared Licensed Vocational Nurse (LVN) 1 was the person that removed the tramadol (from 9/1/24 moving forward) from the blister pack and there was no record of waste nor administration to Resident 71. The CP stated he matched the signature on the ICS to the EMAR so he knew LVN 1 was the nurse who was responsible for the missing medications. The CP stated LVN 1 appeared to be diverting all of these medications. The CP stated the processes in place at the facility were not there to catch a determined thief. The CP stated this would be dangerous for Resident 71 in that their pain would not have been treated per the physician order. The CP stated LVN 1 did not have any pain assessments that would prompt removal of the as needed (PRN) pain medication. During a concurrent observation and interview on 10/2/24 at 6:55 p.m., with Resident 71 in the hallway, Resident 71 sat her in wheelchair with her hands shaking. Resident 71 stated she always had some pain in her body and took gabapentin (medication used to treat nerve pain) for it, but never tramadol. Resident 71 stated she had never taken tramadol to her knowledge. During a concurrent interview and record review on 10/3/24 at 9:30 a.m., with the Assistant Director of Nursing (ADON), Resident 71's Tramadol ICS, dated 8/14/24 to 9/24/24 was reviewed. The inventory control sheet (ICS) indicated 19 tramadol tablets in total were taken from the medication blister pack and not given to Resident 71 per the EMAR, nor wasted on the ICS. The ADON stated because the tramadol was not administered Resident 71 could have suffered in pain. During an interview on 10/3/24 at 10 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he had a lot of patients so he forgot to chart the controlled medications (medications whose use and distribution are tightly controlled because of their abuse potential or risk) in the EMAR. LVN 1 stated he had been working too much and just messed up. During an interview on 10/4/24 at 4:30 p.m., with the Owner/Acting Administrator/Interim DON (same person-OA), the OA stated the expectation for nursing staff was to follow the physician orders for medication administration and document in the EMAR it was given. The OA stated for PRN medication there should be supporting documentation on why the medication needed to be pulled and charted given in the EMAR. The OA stated that it appeared LVN 1 was deliberately taking the medications and potentially forging signatures as reported by other staff. The OA stated this put residents at risk to have negative outcomes in terms of behaviors and pain not being controlled. During an interview on 10/10/24 at 3:45 p.m., with the Director of Nursing (DON), the DON stated the medications that were taken by LVN 1 per the inventory control sheet (ICS) and not given to the resident or wasted, are resident property. The DON stated she would consider that theft because those medications belong to the resident. The DON stated the residents paid for it. During a review of Resident 71 Prescription Summary General [NAME] Information (GI), dated 8/13/24, the GI indicated, .Patient: [Resident 71] . Drug: Tramadol 50 mg . Quantity: 30 . Acquisition Cost: $.70 . Charge Account: [name of facility] MED . (continued on next page)

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	555352	A. Building B. Wing	10/02/2024

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of professional reference Diversion of Drugs Within Health Care Facilities, a Multiple-Victim Crime: Patterns of Diversion, Scope, Consequences, Detection, and Prevention, dated July 2012, (found at https://pmc.ncbi.nlm.nih.gov/articles/PMC3538481/) indicated, .healthcare workers who are diverting drugs from the health care facility workplace pose a risk to their patients, their employers, their co-workers, and themselves. It is essential that all health care institutions have a robust system in place to identify and investigate suspected diversion as rapidly and efficiently as possible and that they implement policies and procedures that enable a standardized and effective response to confirmed diversion. Drug diversion by healthcare workers violates the core value that the needs of the patient come first. Clearly, if we are to optimize our approach to inpatient drug diversion and its consequences, we must look at such diversion not as a victimless act but as a multiple-victim crime . 5. During a review of Resident 73's Face Sheet, the face sheet indicated, Resident 73 was admitted to the facility on [DATE] with diagnosis which included intracerebral hemorrhage (a type of stroke that occurs when a blood vessel in the brain ruptures, causing bleeding into the brain tissue), generalized muscle weakness (a feeling of decreased muscle strength or a need to use extra effort to move muscles). During a review of Resid [TRUNCATED]

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	555352	A. Building B. Wing	10/02/2024

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 27137 Based on interview and record review, the facility failed to check the references for two of five sampled employees (Licensed Vocational Nurse 1 and Licensed Nurse 22) prior to being employed at the facility. This failure had the potential for the facility to employ unqualified and/or abusive staff to provide direct care to residents. Findings: During an interview on 10/18/24, at 10:45 a.m., with the Owner/Administrator (OA), the OA stated it was his expectation that previous employment and personal references checks be done for all candidates considered for employment. During a concurrent record review and interview, on 10/11/24, at 9:25 a.m., with the Director of Staff Development (DSD), Licensed Vocational Nurse (LVN) 1's personnel file was reviewed. There was no indication LVN 1 had any reference checks performed. The DSD stated, We need at least two references. I have no idea where [LVN 1's] references are. During a concurrent record review and interview, on 10/11/24, at 11:55 a.m., with the DSD, LN 22's personnel file was reviewed. The file indicated LN 22 had just graduated nursing school and had no previous nursing experience. Instead of previous employment references, LN 22 had two personal references listed. There was no indication LN 22 had these personal reference checks performed. The DSD confirmed LN 22's two personal references were not checked and stated, I only check employment references but don't check personal references. During a review the facility document titled LVN Charge Nurse, undated, indicated, Job Summary: The charge nurse is to insure that effective, efficient and comprehensive resident care is provided as prescribed by the physician and as required by this facilities polices to no more than 64 residents and to evaluate the duty performance of the [Certified Nursing Assistants] under their charge. During a review of the facility Policy and Procedure (P&P) titled, Background Screening Investigations, dated 3/2019, the P&P indicated, Our facility conducts employment background screening checks, reference checks. on all applicants for positions with direct access to residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on observation, interview and record review, the facility failed to ensure: 1. An adequate system for maintaining controlled drugs (substances that have an accepted medical use and have a potential for abuse and may also lead to physical or psychological dependence) records when facility was unable to provide record account for Resident 63's hydrocodone/acetaminophen (pain medication) 5-325 mg (milligram- unit of measurement), maintenance of records for stored controlled drugs awaiting destruction, maintenance of records for controlled drugs used from the facility's e-kit (emergency kit containing medications for facility use when patient specific medication not available from 7/2024 to 10/2024, and used e-kit was not replenished in accordance with facility policy and procedure. 2. Destruction of controlled drugs not accordance with facility policy and procedure. 3. An adequate system for the Director of Nursing (DON) to reconcile controlled drugs periodically in the facility. These failures resulted in drug diversion of controlled medications in the facility and have the potential to not meet the needs of the residents in the facility. Findings: 1a. During a review of Resident 63's Progress Notes (PN- a document that provides nursing notes regarding resident) dated 6/9/24 to 7/10/24, the PN indicated, Resident 63 was admitted to the facility on [DATE] with diagnosis including contracture (tightening and stiffening) of right upper arm muscle. The PN dated 7/5/24 at 3:38 a.m. indicated 9 tablets of hydrocodone-acetaminophen 5-325 mg were received during admission and stored in the facility's medication cart. The pharmacy medication delivery log, dated 7/6/24, indicated 28 hydrocodone-acetaminophen 5-325 mg tablets for Resident 63 were delivered to the facility. Resident 63's Medication Administration Record (MAR) dated 7/1/24 to 7/31/24, indicated an order for hydrocodone-acetaminophen 5-325 mg, 1 tablet by mouth twice daily starting 7/5/24 at 08:00 a.m. and hydrocodone-acetaminophen 5-325 mg, 1 tablet by mouth every 4 hours as needed for severe pain 7-10, starting 7/5/24 at 3:30 a.m. Resident 63's MAR indicated Resident 63 was administered 1 hydrocodone-acetaminophen 5-325 mg tablet on 7/5/24 and 7/6/24 at 08:00a.m., 8:00 p.m., and 7/7/24 at 8:00 a.m., at total of 5 tablets. During a review of Resident 63's PN dated 7/7/24 at 9:54 a.m., the PN indicated Resident 63 was discharged from the facility with all medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/10/24 at 11:45 a.m., with Assistant Director of Nursing (ADON), ADON stated Resident 63's 32 tablets of hydrocodone-acetaminophen 5-325 mg should have gone with Resident 63 upon discharge. ADON stated the facility did not have a record of transfer for Resident 63's 32 tablets of hydrocodone-acetaminophen 5-325 mg. ADON acknowledged the facility should have records for all controlled drugs and there was no way of knowing what happened with Resident 63's tablets. During an interview on 10/10/24 at 3:05 p.m., with DON, DON was unable to provide documentation for Resident 63's 32 hydrocodone-acetaminophen 5-325 mg tablets. DON acknowledged the facility did not have a record of Resident 63's 32 hydrocodone-acetaminophen 5-325 mg tablets, and stated nursing staff was expected to keep accurate records for controls. DON stated it was important to have record of controlled drugs so facility can reconcile and so that medications will not be in the wrong hands of anyone. During an interview on 10/11/24 at 10:11 a.m., with Consultant Pharmacist (CP), CP stated the expectation was for the facility to have a record and documentation of the controlled drug leaving facility or destroyed. CP stated it was important because the facility is responsible for what controlled medication came in and out of the facility. During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage in the Facility-Controlled Medication Storage, dated August 2014, the P&P indicated, Controlled medications are not surrendered to anyone, including the resident's physician, other than releasing controlled medications for a resident on pass or therapeutic leave, to a resident or responsible party upon discharge from the facility . in exchange for a receipt documenting the transaction. 1b. During an interview on 10/10/24 at 11:38 a.m., with Licensed Nurse (LN) 23, when asked about the facility's process for destruction of controlled drugs, LN 23 stated controlled medications discontinued were removed from narcotic storage in medication cart and given to DON. During an observation and interview on 10/10/24 at 3:05 p.m. with DON, controlled medications were observed to be stored in locked cabinet in DON's office. DON stated for disposition of controlled medications, nursing staff and DON signed count sheet attached to medication count and stored in the cabinet. DON would log in medication and sign with CP when CP came to facility to destroy controlled medications. During an interview on 10/11/24 at 11:11 a.m., with CP, CP stated when doing destruction of controlled medications at the facility, DON would create log sheet for disposition as they did the destruction. CP stated the controlled drug count sheet is signed by giving nurse and DON to verify numbers of tablets. CP acknowledged the facility did not have a record of controlled medications stored awaiting disposition, and that the disposition log being used was inadequate to accurately track controlled drug medications and quantity of tablets given to DON for storage. During an interview on 10/11/24 at 12:05 p.m., with DON, DON stated she had given key to cabinet stored with controlled medications awaiting disposition, to nursing staff. DON acknowledged there was no way to know if someone took controlled medication from cabinet since there was no log of the controlled medications stored. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Medication Storage in the Facility- Controlled Medication Storage, dated August 2014, the P&P indicated, The director of nursing in conjunction with consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during medication storage inspection. 1c. During a review of the pharmacy's e-kit content list provided by the pharmacy, the pharmacy's narcotic (controlled drug) e-kit indicated the following pain medications: 8 hydromorphone 2 mg tablets, 8 methadone 5 mg tablets, 4 0.5-ml (milliliter- unit of measurement) morphine 10 mg/0.5 ml oral syringe, 8 hydrocodone-acetaminophen 5-325 mg, 8 oxycontin 10 mg tablets, 8 hydrocodone-acetaminophen 10-325 mg tablets, 8 oxycodone-acetaminophen 5-325 mg tablets, 8 oxycodone-acetaminophen 10-325 mg tablets, 8 morphine extended release 15 mg tablets, and 8 oxycodone 5 mg tablets. The pharmacy's oral e-kit included the following controlled medications: 4 acetaminophen-codeine #3 tablets (pain medication), 8 alprazolam 0.5 mg tablets (anti-anxiety medication), 3 temazepam 7.5 mg tablets (anti-anxiety medication, 4 zolpidem 5 mg tablets (medication for sleep). During an interview on 10/9/24 at 4:00 p.m., with LN 22, LN 22 stated in order to use the e-kit, nursing staff was expected to look at medication order and call pharmacy for a pin. Nursing staff was expected to write down the pin, open the e-kit, note it in the nursing progress note, fill out the form provided in the e-kit, leave yellow copy in e-kit, fax a copy to the pharmacy and put white copy in DON's box. During an interview on 10/10/24 at 11:34 a.m., with LN 23, LN 23 stated in order to use the e-kit, nursing staff was expected to call the pharmacy and get approval e-kit number only if the nurse did not have the medication on hand. LN 23 stated nursing staff was expected to document form in e-kit box, white and yellow, keep one copy, fax it to pharmacy and leave other copy in e-kit box. During an observation on 10/10/24 at 3:27 p.m., 1 narcotic e-kit and 1 oral e-kit at nursing station 1 and 1 narcotic e-kit and 1 oral e-kit at nursing station 2. During a review of the pharmacy e-kit dispense log history, undated, the pharmacy e-kit dispense log history indicated the pharmacy delivered 4 oral e-kits on 7/31/24, 9/9/24, 9/12/24, 9/26/24 and 3 narcotic e-kits on 7/19/24, 9/9/24, 9/26/24 to the facility's station 1; 4 oral e-kits on 8/12/24, 9/9/24, 9/12/24, 9/26/24 and 3 narcotic e-kits on 7/19/24, 9/9/24, 9/26/24 to the facility's station 2. During an interview and record review on 10/11/24 at 10:14 a.m., with DON, e-kit log dated 9/21/24 provided by the pharmacy was reviewed. When asked about the e-kit log records, DON was unable to provide e-kit usage records between the months of 7/2024 to 10/2024. DON stated when nursing staff opened an e-kit, the expectation was to inform pharmacy, get approval, have another nurse check medication, complete form provided in e-kit with a 2-nurse signature, and call for replacement of e-kit immediately. DON acknowledged the process was not done by nursing staff and stated the documentation should have been placed in the e-kit binder. DON stated it was important to track controlled drugs used from the e-kit so record is available. During a review of the e-kit log dated 9/21/24, the e-kit log indicated 1 hydrocodone-acetaminophen 5-325 mg was taken out of station 1's narcotic e-kit for a resident's use on 9/21/24. DON acknowledged station 1's e-kit was not replaced immediately and was replaced on 9/26/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/11/24 at 11:09 a.m., with CP, CP stated the expectation was for nursing staff to document every medication taken from the e-kit. CP stated it was important for billing, inventory tracking, narcotic control policy, and to detect, deter, and prevent drug diversion. CP stated nursing staff was expected to call pharmacy prior to opening e-kit to get authorization, document authorization on e-kit log, medication name and quantity, fax refill tag to pharmacy to get e-kit replaced within 72 hours from when e-kit is opened. CP acknowledged e-kit used on 9/21/24 at station 1 was not replaced within 72 hours. CP stated if the e-kit is not replaced within 72 hours, another resident may need medication that may have been depleted, lowering the chance of providing medication that may be needed in emergency situation. During a review of the e-kit pharmacy log form, undated, the e-kit pharmacy log form instructions indicated, call order into pharmacy, fill out all appropriate areas in log (date, time ordered, patient name, drug name and strength, directions, quantity, physician, pharmacist approved, time given, nurse name and signature, when completed, place top copy on pharmacy log clipboard, return yellow copy to pharmacy in emergency kit. Retain white copy for 3 years. During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy- Emergency Pharmacy Service and Emergency Kits, dated August 2014, the P&P indicated, When an emergency or state dose of a medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication, complete the emergency e-kit slip and re-seal the emergency supply. An entry is made in the emergency logbook containing all required information . A record of the name, dose of the drug administered, name of the patient, date, time of administration, and signature of the person administering the dose shall be recorded in the emergency logbook . If exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening 2. During an interview on 10/10/24 at 11:31 a.m., with LN 23, when asked about destruction of controlled medications, LN 23 stated destruction of controlled medications refused by residents was witnessed and signed by another nurse. LN 23 stated the controlled medication was destroyed by dissolving the tablet in water and dumped in the medication bin. During an interview on 10/10/24 at 12:13 p.m., with ADON, ADON stated destruction of controlled medications was done by two nurses witnessing destruction and signing controlled medication count sheet. ADON stated a drug buster (medication disposal system deactivates and contains the active ingredients in non-hazardous medications) was supposed to be at each cart so nursing staff can use to dispose controlled medication, and that it had been ordered. ADON acknowledged staff was dissolving controlled medication in water and stated it was not an appropriate method to destroy controlled medications. During an interview on 10/10/24 at 3:53 p.m., with DON, DON stated destruction of controlled medications was done by two nurses witnessing destruction and signing controlled medication count sheet. DON stated nursing staff had been dissolving controlled pills in water and putting in blue bin, but it was supposed to be mixed with drug buster. DON stated if controlled medications were not properly destroy, someone could have access to medication. During an interview on 10/11/24 at 11:26 a.m. with CP, CP stated it was not appropriate to dissolve controlled medications in water. (continued on next page)

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	555352	A. Building B. Wing	10/02/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Discarding and Destroying Medications, dated October 2014, the P&P indicated, Destruction of a controlled substance must render it non-retrievable, meaning that the process permanently alters the physical or chemical properties of the substance so that it is no longer available or usable, and can be illegally diverted. 3. During an interview on 10/10/24 at 3:46 p.m. with DON, when asked about the process for periodic reconciliation of controlled medications, DON stated incoming and outgoing nursing staff was expected to sign the narcotic count sheet at change of shift. DON acknowledged the facility did not have a process for periodic reconciliation in place and stated she had never encountered diversion, and this was a big learning process for her. During a review of the facility's P&P titled, Medication Storage in the Facility- Controlled Medication Storage, dated August 2014, the P&P indicated, The director of nursing in conjunction with consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during medication storage inspection.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41166 Based on interview and record review, the facility failed to ensure three of seven sampled residents (Residents 55, 57, 59) were administered medications appropriately when: 1. Resident 55's oxycodone (controlled pain medication that has a potential for abuse and may also lead to physical or psychological dependence) order was changed from as needed (given to resident only if needed on scheduled time) to routine (given to resident around continuously on scheduled time) without clinical justification, with no side effect monitoring. 2. Resident 57's hydrocodone-acetaminophen (controlled pain medication that has a potential for abuse and may also lead to physical or psychological dependence) 5-325 mg (milligram- unit of measurement) order was changed with the addition of an additional hydrocodone-acetaminophen 5-325 mg order without clinical justification, with no side effecting monitoring. 3. Resident 59's tramadol (controlled pain medication that has a potential for abuse and may also lead to physical or psychological dependence) 50 mg order was changed from three times daily to four times daily without clinical justification, with no side effect monitoring. These failures had a potential for Residents 55, 57, and 59 to be administered controlled pain medications unnecessarily, and for the potential of medication interactions, adverse reactions including sedation, respiratory depression, and constipation. Findings: 1. During a review of Resident 55's Admission Record (AR), dated 10/9/24, the AR indicated Resident 55 was admitted to the facility on [DATE] from an acute care hospital. During a review of Resident 55's Minimum Data Set (MDS-assessment to evaluate a person's health status, functional abilities and needs), dated 7/12/24, the MDS indicated, Resident 55 had a Brief Interview for Mental Status (BIMS- assessment for a person's ability to process and understand information) score of 0 for severe difficulty in learning, remembering, concentrating, or making decisions. During a review of Resident 55's Order Audit Report ([NAME]), dated 10/9/24, the [NAME] indicated physician orders for oxycodone 5 mg every 4 hours as needed for pain from 7/9/24 to 7/12/24, and oxycodone 10mg three times daily from 7/12/24 to 8/3/24, 8/7/24 to present. During a review of Resident 55's Medication Administration Record (MAR) dated 7/1/24 to 7/31/24, Resident 55's MAR indicated, Resident 55 was administered one oxycodone 5 mg tablet as needed on 7/11/24 at 1:00 a.m., 8:06 a.m., 5:45 p.m., 8:43 p.m. and on 7/12/24 at 4:27 a.m. for a total of 5 oxycodone 5mg tablets from 7/9/24 to 7/12/24, and 112 oxycodone 5 mg tablets from 7/12/24 to 7/31/24 routinely at 8:00 a.m., 12:00 noon, and 9:00 p.m. During an interview on 10/9/24 at 3:43 p.m. with Licensed Nurse (LN) 22, when asked about Resident 55, LN 22 stated Resident 55 did not speak English, but spoke with LN 22 because they spoke the same language. LN 22 stated Resident 55 did not complain about being in pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Conv. Hospital	2939 S. Peach Avenue Fresno, CA 93725

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/24 at 11:38 a.m., with LN 22, when asked about the facility's process for destruction of controlled drugs, LN 22 stated controlled medications discontinued were removed from narcotic storage in medication cart and given to DON. During a concurrent interview and record review on 10/10/24 at 12:16 p.m. with Assistant Director of Nursing (ADON), Resident 55's clinical records were reviewed. ADON stated if a resident's pain was not managed with the current pain medication order, nursing staff can ask for a stronger pain medication. ADON stated if a resident was continuously requesting a pain medication ordered as needed, then nursing would request for a change from as needed to routine but not after 1 or 2 days of the medication being ordered. ADON acknowledged Resident 55's oxycodone order was changed from as needed to routine after 2 days of being ordered and 5 doses being administered. ADON was unable to provide documentation as to why Resident 55's oxycodone order was changed from as needed to routine by nursing staff. ADON stated the expectation was for nursing staff to document in progress note why the order was being changed, update the care plan and carry out the order. During a telephone interview on 10/10/24 at 2:50 p.m. with Medical Director (MD), MD stated it was unusual for him to prescribe an oxycodone as a routine order and did not recall changing Resident 55's oxycodone order from as needed to routine. During a interview and record review on 10/10/24 at 3:23 p.m. with Licensed Nurse Supervisor (LNS), Resident 55's clinical record was reviewed. LNS stated Patient 55 needed to be assessed as to whether the oxycodone as needed order was effective for pain management, but 48 hours was not enough time to assess and change oxycodone order from as needed to routine. LNS stated the expectation was for nursing staff to document communication with physician on the progress note, and care plan for pain. LNS was unable to provide an updated care plan for Resident 55's pain management, assessment for Resident 55's pain prior to change in oxycodone order from as need to routine, as well as communication with physician as to why oxycodone order was changed from as needed to routine. 2. During a review of Resident 57's AR, dated 10/9/24, the AR indicated Resident 57 was admitted to the facility on [DATE] from an acute care hospital. During a review of Resident 57's [NAME], dated 10/9/24, the [NAME] indicated current physician orders for hydrocodone-acetaminophen 5-325 mg every 6 hours as needed for moderate pain from 6/26/24 to present, and hydrocodone-acetaminophen 5-325 mg three times daily from 7/4/24 to present. During a review of Resident 57's MAR, dated 6/1/24 to 6/30/24 and 7/1/24 to 7/31/24, Resident 57's MAR indicated Resident 57 was administered one hydrocodone-acetaminophen 5-325 mg tablet on 6/28/24 at 08:00 a.m., and on 6/30/24 at 8:35 a.m., 4:30 p.m. for a total of 3 hydrocodone-acetaminophen 5-325 mg tablets as needed from 6/26/24 to 7/4/24, and 84 tablets from 7/4/24 to 7/31/24. During an interview on 10/9/24 at 3:45 p.m., with LN 22, LN 22 stated Resident 57 was able to communicate but was developmentally delayed and did not complain about pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 10/10/24 at 10:58 a.m., with ADON, Resident 57's clinical records were reviewed. A review of Resident 57's progress note dated 7/4/24 at 8:26 a.m., indicated, Notified md [doctor] via phone regarding resident's chronic pain, received order to make [hydrocodone-acetaminophen] 5-325 to routine to TID [three times daily]. Resident alert and oriented . During a review of Resident 57's clinical records including Resident 57's MDS, Section I for Active Diagnoses, dated 10/1/24, ADON was unable to find documentation for a diagnosis of chronic pain. ADON acknowledged Resident 57 did not have a history of chronic pain and stated it was not appropriate for nursing staff to obtain a routine order for hydrocodone-acetaminophen 5-325 mg three times daily for Resident 57, when Resident 57 had only requested and had been administered 3 doses of hydrocodone-acetaminophen 5-325 mg as needed. ADON stated, Resident 57's as needed hydrocodone-acetaminophen 5-325 mg order could indicate acute pain, and it was important not to give too much pain medication because of side effects like constipation and potential for resident to become addicted to medication. ADON was unable to provide documentation of a pain assessment for Resident 57 prior to addition of hydrocodone-acetaminophen routine order on 7/4/24. During a telephone interview on 10/10/24 at 2:50 p.m. with MD, MD stated he did not recall prescribing hydrocodone-acetaminophen 5-325 mg three times daily routinely for Resident 57. 3. During a review of Resident 59's AR, dated 10/9/24, the AR indicated Resident 59 was admitted to the facility on [DATE]. During a review of Resident 59's MDS dated [DATE], the MDS indicated, Resident 59 had a BIMS score of 0 for severe difficulty in learning, remembering, concentrating, or making decisions. During a review of Resident 59's [NAME], dated 10/9/24, the [NAME] included physician orders for tramadol 50 mg every 6 hours as needed for moderate to severe pain from 4/9/24 to 9/5/24, tramadol 50 mg three times daily from 4/9/24 to 7/18/24, and tramadol 50 mg four times daily for 7/18/24 to present. During a review of Resident 59's MAR dated 7/1/24 to 7/31/24, Resident 59's MAR indicated Resident 59 was indicated one tramadol 50 mg tablet on 7/1/24 at 4:00 p.m., 7/3/24 at 4:00 p.m., 7/10/24 at 4:00 p.m., and 7/17/24 at 4:00 p.m., for a total of 4 tramadol 50 mg tablets as needed from 7/1/24 to 7/18/24. During a concurrent interview and record review on 10/10/24 at 12:42 p.m., with ADON, Resident 59's clinical records were reviewed. A review of Resident 59's progress note dated 7/18/24 at 4:59 p.m., indicated, Spoke with md [doctor] via phone resident continues to request prn tramadol around same time 4-6 pm. Notified md and asked if he can have it QID [four times daily] instead of TID [three times daily]. Resident in agreement. ADON acknowledged Resident 59 requested and was administered 4 doses of tramadol 50 mg as needed from 7/1/24 to 7/18/24. ADON stated that Resident 59's usage of tramadol 50 mg as needed order did not warrant a change of Resident 59's tramadol routine order from three times daily to four times daily. ADON was unable to provide documentation of a pain assessment for Resident 59 prior to change of tramadol routine order from three times daily to four times daily on 7/18/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Conv. Hospital	2939 S. Peach Avenue Fresno, CA 93725

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/24 at 4:01 p.m., with DON, when asked about nursing staff progress note regarding Resident 57's change in hydrocodone orders, dated 7/4/24, and Resident 59's change in tramadol orders, dated 7/18/24, DON stated it was not appropriate for nursing staff to call physician for increased dosage of controlled pain medication. DON stated, If patient taking pain medication occasionally why, only put patient on routine [pain medication] if patient is complaining of pain all the time. DON stated if a resident was administered a controlled pain medication and they didn't need it, resident could overdose or become very sedated. DON stated the expectation was for nursing staff to also do a care plan for pain for the resident. During a concurrent interview and record review on 10/11/24 at 12:12 p.m. with DON, Residents 55, 57, and 59's care plan for pain, and MAR were reviewed. DON acknowledged Resident 57 did not have a pain management care plan, and Resident 55 and 59's care plan for pain was not updated after dosage increase in Resident 55's oxycodone on 7/12/24, and dosage increase in Resident 59's tramadol order on 7/18/24. DON also acknowledged Residents 55 and 59's pain care plans did not have treatment goals so nursing staff was unable to determine if residents were meeting their goals for pain treatment, and whether to increase or decrease Residents 55, 57 and 59's controlled pain medications. DON was unable to provide documentation for monitoring of Resident 55's oxycodone 5 mg, Resident 57's hydrocodone-acetaminophen 5-325 mg, and Resident 59's tramadol 50 mg administrations. DON stated if a patient developed side effect, nursing staff was expected to stop medication and notify physician. During a review of the facility's Policy and Procedure (P&P) titled, Pain Assessment and Management, revised October 2022, the P&P indicated, Assessing Pain . The resident's goals for pain management and his or her satisfaction with the current level of pain control . The pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan . When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. Any resident who uses opioids for long-term management of chronic pain is at risk for opioid overdose . If the resident is prescribed opioid analgesics, monitor for the following side effects: a. tolerance, meaning more medication may be needed to achieve the same level of pain relief; b. physical dependence which causes symptoms of withdrawal when opioid medication is stopped, or a dose is held or missed c. increased sensitivity to pain d. constipation e. nausea, vomiting and dry mouth f. sleepiness, dizziness and/or confusion g. depression and h. itching and sweating . Upon completion of the pain assessment, the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 27137 Based on interview and record review, the facility administration failed to ensure one of one sampled employee, Licensed Vocational Nurse (LVN) 1, did not work in the facility while he was suspended from employment and under investigation for drug diversion (theft of resident medications), when he returned to work in the facility with approximately 30 residents during one 12-hour shift. This failure had the potential for further drug diversion, evidence tampering, falsification of records, or other investigation interference. Findings: During a review of the Centers for Disease Control (CDC) website titled, Clinician Brief: Drug Diversion, dated 3/18/24, the CDC website indicated, Drug diversion happens when healthcare providers obtain or use prescription medicines illegally. Drug diversion puts patients at risk. Some healthcare providers steal prescription medicines or controlled substances, such as opioids [highly addictive, narcotic medications that can produce a powerful feeling of well-being, or a 'high', in the brain], for their own use. Addiction to opioids is a major driver of drug diversion. This behavior leads to unsafe situations like: An impaired healthcare provider delivering substandard care. During an interview on 10/10/24, at 11:34 a.m., with the Owner/Administrator (OA), the OA stated LVN 1 had been suspended from employment on 9/25/24 due to being suspected of drug diversion, including opioid and other addictive medications. The OA stated the Director of Nursing (DON) was tasked with investigating the possible drug diversion. The OA stated that while still suspended, the DON asked LVN 1 to return to work and provide orientation to a newly hired LVN (Licensed Nurse, or LN, 22), for a 12-hour shift, on 9/28/24. The OA stated, In my opinion, no, it was not ok for him to return to work while on suspension to shadow [LN 22]. He was still on suspension on 9/28/24, the investigation was ongoing. Not ok because when somebody is on suspension, we want to maintain employee suspension. During an interview on 10/10/24, at 12:22 p.m., with the DON, the DON stated she had told LVN 1 he was suspended on 9/26/24. The DON stated she was investigating the issue of drug diversion, which involved LVN 1. The DON stated she asked LVN 1 to come into work on 9/28/24, while the drug diversion investigation was still ongoing, to provide orientation to LN 22. The DON stated LVN 1 worked a 12-hour shift on 9/28/24. During an interview on 10/10/24, at 2:10 p.m., with LN 22, LN 22 stated she recalled working with LVN 1 on 9/28/24. LN 22 stated LN 1 worked with her for the entire 12-hour shift while she passed medications to about 30 residents. During an interview on 10/10/24, at 3:45 p.m. with the DON, the DON stated that medications are the property of the resident. The DON stated that drug diversion is theft because those medications belong to the resident, they are their property. (continued on next page)

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	555352	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Conv. Hospital	2939 S. Peach Avenue Fresno, CA 93725

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/24, at 10:45 a.m., with the OA, the OA stated the DON was suspended on 10/7/24, when he learned that the DON brought back LVN 1 to work, while suspended, on 9/28/24. The OA stated, I gave her specific instructions that [LVN 1] was not to be in the building while he was suspended. The OA stated that the DON asked him if she could bring LVN 1 back into the facility during the suspension to train LVN 22, and the OA stated, I told her no, because [LVN 1] is suspended, and he is not to come into work. I thought I made that clear. The OA stated he told the DON there were other nurses that could have provided orientation to LN 22, and, I told her I gave you specific instructions, and you still did it. It was insubordination. I didn't want [LVN 1] in the facility at all during the investigation, that was why [the DON was suspended]. During a review of the facility Policy and Procedure (P&P), titled, Abuse, Neglect, Exploitation, or Misappropriation - Reporting and Investigating, the P&P indicated, in part, All reports of resident abuse (including injury of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported . and thoroughly investigated by facility management. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete.

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	555352	A. Building B. Wing	10/02/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 27137 Based on observation, interview, and record review, the facility failed to ensure two of two Licensed Nurses (Registered Nurse, or RN 3, and Licensed Nurse, or LN, 22) properly disinfected a glucometer (a handheld device used to measure how much sugar is in a drop of blood) after obtaining a blood sample from residents. This failure had the potential to spread bloodborne diseases via the glucometer to as many as nine other residents also receiving these blood tests. Findings: During a review of the website page for the Centers for Disease Control (CDC), titled, Considerations for Blood Glucose Monitoring and Insulin Administration, the website page indicated, Blood glucose meters [also known as glucometers] are portable devices that measure blood glucose levels and aid in diabetes [a chronic and serious disorder where glucose, a type of sugar, is poorly regulated in the blood] . management. Healthcare providers use these types of devices in a variety of clinical settings. Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents. Viruses like HIV, hepatitis B, and hepatitis C can spread in health care through contact with contaminated blood. Items that cause a cut or break in someone else's skin, like fingerstick blood specimens, can spread viruses in blood and cause new infections. Fingerstick devices . prick the skin to obtain drops of blood for testing. Reusing equipment like glucometers. is especially risky because germs in the blood can spread from one person to another. Viruses in blood can live on surfaces and spread even when blood is not visible. During an interview with Licensed Nurse (LN) 22, on 10/11/24, at 10:25 a.m., LN 22 stated she was assigned to administer medications to about half the residents in the facility. LN 22 stated there were four residents that needed a blood glucose fingerstick test performed at least once during her shift today. LN 22 stated she had been an employee of the facility for about one week and not received competency-based training on a glucometer. During an interview with Registered Nurse (RN) 3, on 10/11/24, at 10:28 a.m., RN 3 stated she was assigned to administer medications to about half the residents in the facility. RN 3 stated there were five residents that needed a blood glucose fingerstick test performed at least once during her shift today. RN 3 stated she has been an employee of the facility for about three months and had not received competency-based training on a glucometer. During a concurrent observation and interview on 10/11/24, at 11:16 a.m., RN 3 was noted performing a blood glucose fingerstick on Resident 90, at his bedside, using a brand name glucometer. After the test was performed, RN 3 brought the glucometer back to the medication cart and wiped the glucometer with [brand name] Disinfecting Wipes, for about 10 seconds. The [brand name] Disinfecting Wipes were dispensed from a cannister which gave no indication the product was useful or effective against bloodborne diseases. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/11/24, at 11:30 a.m., LN 22 was noted performing a blood glucose fingerstick on Resident 57, at his bedside, using a brand name glucometer. After the test was performed, LN 22 brought the glucometer back to the medication cart and wiped the glucometer with a [brand name] Germicidal Disposable Wipe, for about 10 seconds. The [brand name] Germicidal Disposable Wipe was dispensed from a cannister that indicated effectiveness against bloodborne diseases and indicated, Disinfects in 2 minutes. LN 22 stated, I cleaned the glucometer machine for like 10 seconds. During an interview on 10/11/24, at 3 p.m., with the Infection Prevention Nurse (IPN), the IPN stated RN 3 should not have used the [brand name] Disinfecting Wipes to disinfect the glucometer, because that product is not approved for killing bloodborne germs. The IPN stated RN 3 should have used the [brand name] Germicidal Disposable Wipe to disinfect the glucometer as it is approved to kill bloodborne germs. The IPN stated both RN 3 and LN 22 should have wiped the glucometer with the [brand name] Germicidal Disposable Wipe for two minutes, as directed on the product cannister. During a review of the Technical Brief (TB) for the brand name glucometer, dated 10/23, the TB indicated, The meter should be cleaned and disinfected after use on each patient. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens. [The manufacturer] recommends using these wipes to clean and disinfect the [brand name] meter: [brand name] Germicidal Disposable Wipes[.] Select a wipe . and carefully review the manufacturer's instructions. During a review of the Technical Data Bulletin (TDB) for [brand name] germicidal disposable wipes, dated 2023, the TDB indicated the product is effective against bloodborne pathogens and organisms if exposed to the liquid in the wipes for two minutes.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 27137 Based on interview and record review, the facility failed to ensure three of three nursing staff (Licensed Vocational Nurse 1, Licensed Nurse 22, and Registered Nurse 3) received essential competencies were conducted on new staff hired by the facility. This failure had the potential for incompetent or untrained nursing staff to deliver care to residents. Findings: During a concurrent record review and interview, on 10/11/24, at 9:25 a.m., with the Director of Staff Development (DSD), Licensed Nurse (LN) 22's personnel file and training records was reviewed. The DSD stated he was responsible for overseeing and directing the orientation of new nursing staff. The DSD stated new nurses are to have two classroom days of orientation before they work the floor providing care to residents. The DSD stated LN 22 only had one day of classroom orientation before she was instructed by the Director of Nursing (DON) to go work on the floor on her second day. The DSD stated the DON made this decision as a shortcut and to start LN 22 working directly with residents as soon as possible. The DSD stated, the DON didn't ask him, but she needed a nurse on the floor. During a concurrent record review and interview, on 10/11/24, at 9:25 a.m., with DSD, Licensed Vocational Nurse (LVN) 1, LN 22, and RN 3's personnel file and training records was reviewed. The DSD verified there were no glucometer (a handheld device used to measure how much sugar is in a drop of blood, used to monitor and treat diabetes) competencies found in the records for LVN 1, LN 22, or RN 3. The DSD stated there were about eight to ten residents in the facility that require the use of the glucometer. During an interview on 10/11/24, at 11:25 a.m., with LN 22, LN 22 stated she did not receive competency-based training for the use of a glucometer. During an interview on 10/11/24, at 11:28 a.m., with RN 3, RN 3 stated she did not receive competency-based training for the use of a glucometer. During a concurrent record review and interview, on 10/11/24, at 9:25 a.m., with DSD, LVN 1, LN 22, and RN 3's personnel file and training records was reviewed. The DSD verified there were no medication administration competencies found in the records to indicated they were competent on administering medications to the facility's residents via the different methods and routes prescribed by their physician for LVN 1, LN 22 or RN 3. The DSD stated that nurses in the facility administer medications via the mouth; under the tongue; in the eye, ear, nose; on the skin; administer injections into the skin, fat tissue, and muscle; administer breathing treatments that are inhaled; administer medications administered via a tube surgically inserted into the stomach; and administer medications into the rectum. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyside Conv. Hospital	2939 S. Peach Avenue Fresno, CA 93725

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Facility Assessment (FA), dated 9/2/24, the FA indicated the facility had 64 available beds, and All our residents receive medication management. The FA indicated We provide the staff training/education and competencies that are necessary to provide the level and types of support and care needed for our resident population. The following training topics are part of our training program: Medication Administration. diabetic blood glucose testing.

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Sunnyside Conv. Hospital	2939 S. Peach Avenue Fresno, CA 93725

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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 27137 Based on interview and observation, the facility failed to have an effective QAPI (Quality Assurance and Performance Improvement) program when four of four sampled staff (Licensed Nurse 22, Certified Nursing Assistant 1 and 2, and Registered Nurse Supervisor) were not aware of the facility's QAPI plan, and failed to have a tool for measuring Performance Improvement. This failure led to nursing staff being unable to verbalize an understanding of the facility's active performance improvement goals aimed at successfully implementing a program to improve resident safety. Findings: During an interview on 10/10/24, at 3:45 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 was not aware of the facility's QAPI program. CNA 1 stated, No, not heard of that. During an interview on 10/10/24 at 3:50 p.m., with CNA 2, CNA 2 was not aware of the facility's QAPI program. During an interview on 10/10/24 at 3:52 p.m., with Licensed Nurse (LN) 22, LN 22 was not aware of the facility's QAPI program. During an interview on 10/10/24, at 3:55 p.m., with the Registered Nurse Supervisor (LNS), the LNS knew what the QAPI acronym stood for but was unable to describe the facility's QAPI plan or PI measurement. During an observation on 10/10/24, at 3:57 p.m., of a facility bulletin board located near the nursing station, the bulletin board indicated QAPI in large capital letters; the words Performance Improvement fashioned into an arrow; the arrow pointed toward a 8.5 inch by 11 inch sheet of paper that indicated steps on how to reduce pressure ulcers (injuries that usually occur over the bony parts of the body, often due to immobility); and the words LETS WORK TOGETHER TO REDUCE OUR PRESSUE ULCERS BY 50% OVER THE NEXT QUARTER. During an interview on 10/11/24, at 2:30 p.m., with the Director of Nursing (DON), the DON stated the facility collects QAPI data for falls and wounds such as pressure ulcers but was unable to state what the Performance Improvement measurement tool was to improve pressure ulcers. QAPI P&P

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555352	A. Building B. Wing	10/02/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 27137 Based on interview, and record review, the facility failed to implement an effective training program for infection control and prevention for two of three Licensed Nurses (Licensed Vocational Nurse 22, and Registered Nurse, or RN 3), when LN 22 and RN 3 did not have documented training on hand hygiene and personal protective equipment (PPE, items such as gloves, gowns, and masks). This failure placed residents at a risk for potential spread of infection from the Licensed Nurses' lack of training on infection control. Findings: During a concurrent interview and record review on 10/11/2024 at 9:30 AM with Director of Staff and Development (DSD), Licensed Vocational Nurse (LN)22's employee record was reviewed. The employee record indicated, LN 22 did not have signatures indicating training on hand hygiene and personal protective equipment. DSD stated, It is blank, it was not done. During a concurrent interview and record review on 10/11/2024 at 11:55 AM with DSD, RN 3's employee record was reviewed. The employee record indicated, Registered Nurse (RN) 3 did not have signatures indicating training on hand hygiene and personal protective equipment. DSD stated, If not in their record, it is not done. During an interview on 10/11/12024 at 3:15 PM with Infection Preventionist (IP), IP stated, Hand Hygiene and PPE should be mandatory. IP stated she did not ensure that all staff received the training. During a review of the facility's Facility Assessment (FA), dated 9/2/24, the FA indicated, We provide the staff training/education and competencies that are necessary to provide the level and types of support and care needed for our resident population. The following training topics are part of our training program: Infection control - Includes as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program.