| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555352 | A. Building<br>B. Wing | 09/13/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunnyside Conv. Hospital | 2939 S. Peach Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641<br><br>Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for one of four sampled residents (Resident 15) when Certified Nurse Assistant (CNA) 9 did not provide privacy while providing personal hygiene care to Resident 15.<br><br>This failure resulted in Resident 15 not being provided with respect and dignity while receiving care.<br><br>Findings:<br><br>During an observation on 9/12/24 at 9:30 a.m. in the hallway outside Resident 15's room, the door was open and Resident 15 was lying in bed, his buttocks were uncovered, exposed and visible from the hallway to visitors, staff and other residents. Certified Nursing Assistant (CNA) 9 was standing on the side of the bed providing personal hygiene care to Resident 15, the privacy curtain was not drawn past the foot of Resident 15's bed.<br><br>During a review of Resident 15's Admission Record, dated 9/11/24, the Admission Record indicated, Resident 15 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and psychosis (group of symptoms that cause a person to lose touch with reality).<br><br>During a review of Resident 15's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 15's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 12 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 15 had moderate cognitive deficit.<br><br>During an interview on 9/12/24 at 9:43 a.m. with CNA 9, CNA 9 stated the privacy curtain to cover Resident 15 used during personal hygiene care was stuck at the foot of the bed. CNA 9 stated she could not use the privacy curtain and thought she closed the door for privacy. CNA 9 stated she should have made sure the door was closed so she could provide Resident 15 his privacy.<br><br>(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: 555352 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/13/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunnyside Conv. Hospital | 2939 S. Peach Avenue<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/12/24 at 2:13 p.m. with the Director of Staff Development (DSD), the DSD stated CNA 9 should have made sure Resident 15 was covered, curtains and doors were closed before she provided care to Resident 15. DSD stated, .It is a dignity and privacy issue, other residents, staff and visitors are always walking by and could see what was going on inside the room . DSD stated CNA 9 should have made sure she closed the door knowing the privacy curtain was not working.<br><br>During an interview on 9/13/24 at 10:05 a.m. with CNA 10, she stated providing privacy to residents was very important because it is one of their rights and must be respected. CNA 10 stated staff needed to make sure privacy curtains are drawn and doors closed when providing care to residents.<br><br>During an interview on 9/13/24 at 2:15 p.m. with the Director of Nursing (DON), the DON stated, . Residents have rights and one of those rights is to have privacy . DON stated her expectation was for staff to provide privacy when providing care to residents. DON stated the CNA 9 should have made sure she covered Resident 15 and made sure the door was closed when she knew privacy curtain was not working. DON stated residents, staff and visitors are always walking by and did not have to see what was going on inside the room.<br><br>During a review of facility's policy and procedure (P&P) titled, Resident Rights. dated 12/16, the P&P indicated, .a dignified existence; be treated with respect, kindness and dignity . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555352 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/13/2024 |
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| NAME OF PROVIDER OR SUPPLIER Sunnyside Conv. Hospital | | STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. Peach Avenue Fresno, CA 93725 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424<br><br>Based on interview and record review, the facility failed to ensure one of seven residents (Resident 19) was free from abuse and neglect when Resident 19 did not receive the supplies he requested to conduct suprapubic catheter (a hollow flexible tube surgically inserted below the belly button used to drain urine from the bladder) care.<br><br>This failure resulted in Resident 19 soiling himself with urine.<br><br>Findings:<br><br>During a review of Resident 19's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 9/12/24, the AR indicated, Resident 19 was admitted on [DATE] to the facility. Resident 19 had the following diagnoses: quadriplegia (partial or total loss of use of all four limbs and torso), neuromuscular dysfunction of bladder (a condition which affects bladder control due to damage to the nervous system), and depression (mood disorder which causes extreme sadness).<br><br>During a review of Resident 19's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 6/4/24, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 19 had no cognitive impairment.<br><br>During a review of Resident 19's Order Summary Report, dated 9/12/24, indicated, . resident is able to change his own suprapubic catheter tube monthly/PRN (as needed) with licensed staff supervision or assistance when needed .<br><br>During a review of Resident 19's care plan, dated 9/13/24, the care plan indicated, . [Resident 19] prefers to change his own suprapubic catheter due to his desire for independence . approved by the urologist (a medical doctor specializing in conditions that affect the urinary tract) .<br><br>During a concurrent observation and interview on 9/11/24 at 4:41 p.m. with Resident 19 near the nurse's station, Resident 19 was seen in his wheelchair with his pants soiled with urine. Resident 19 stated he had asked staff members to provide the supplies to change his suprapubic catheter. Resident 19 stated he had alerted three staff members and none of them gave him his supplies.<br><br>During an interview on 9/11/24 at 4:55 p.m. with licensed vocational nurse (LVN) 1, LVN 1 stated Resident 19 had asked for supplies to change his suprapubic catheter, but she forgot to give them to him. LVN 1 stated Resident 19 should have received his supplies when he requested them since he is independent and can do a lot of his own care himself.<br><br>(continued on next page) |

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| 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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/12/24 at 3:26 p.m. with the infection preventionist (IP), the IP stated Resident 19 should have been provided the supplies he needed to change his catheter. The IP stated if Resident 19's urine was not released it could have backed up into his bladder and kidneys and caused an infection.<br><br>During an interview on 9/13/24 at 9:53 a.m. with certified nursing assistant 1 (CNA), CNA 1 stated Resident 19 did not need much help when it came to his care. CNA 1 stated Resident 19 was very independent and did a lot of things on his own. CNA 1 stated Resident 19 was alert and oriented and was capable of making all his need known. CNA 1 stated there was no reason for staff to neglect him.<br><br>During an interview on 9/13/24 at 10:08 a.m. with registered nurse (RN) 1, RN 1 stated Resident 19 was very independent, he knew how to care for his own catheter, and he knows when there are problems happening to his catheter. RN 1 stated Resident 19 was a very clean person because he lets staff know when he needs help, and he was always on top of his care. RN 1 stated staff members should not have neglected Resident 19 and staff should have provided Resident 19 the supplies to change his catheter when he requested them. RN 1 stated Resident 19 may have been embarrassed when he was covered with urine because it was not normal for him to be soiled with urine, he was very independent and clean.<br><br>During an interview on 9/13/24 at 10:36 a.m. with the assistant director of nursing (ADON), the ADON stated he was present when Resident 19 came to the nurse's station soiled with urine. The ADON stated Resident 19 was upset he had been neglected by the staff members he requested his items from. The ADON stated Resident 19 was a very independent and aware. The ADON stated the staff should have provided the supplies Resident 19 needed when he requested them.<br><br>During an interview on 9/13/24 at 1:38 p.m. with the director of staff development (DSD), the DSD stated Resident 19 had been upset because he was soiled with urine as a result of staff neglecting to help him when he asked. The DSD stated Resident 19 was very independent and doesn't need much help which caused him to be upset when no one helped him. The DSD stated all the staff members Resident 19 approached for help should have assisted him immediately.<br><br>During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 12/16, indicated, .1. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to: a. a dignified existence b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect<br><br>During a review of the facility's P&P titled, Suprapubic Catheter Care, dated 10/10, indicated, . should the resident indicate his or her bladder is full or that he or she needs to void, report it immediately to your supervisor . |

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

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424<br><br>Based on interview and record review, the facility failed to notify the Long Term Care Ombudsman office (LTC-Ombudsman, a resident advocacy agency) of transfer to the hospital for one of four sampled residents (Resident 26) when the facility failed to send a copy of Resident 26's transfer notification to the local LTC-Ombudsman office.<br><br>This failure resulted in the LTC-Ombudsman not aware of Resident 26's emergency transfer to an acute care facility for treatment on 5/24/24.<br><br>Findings:<br><br>During a review of Resident 26's Admission Record (AR, documents containing resident demographic information and medical diagnosis), dated 9/12/24, the AR indicated Resident 26 was admitted to the facility on [DATE] with diagnoses which included hydronephrosis (a condition that occurs when urine builds up in the kidney, causing it to swell and stretch), infection (invasion and growth of germs in the body) due to nephrostomy (a surgical procedure that creates an opening in the kidney to drain urine or for other purposes) , and diabetes mellitus (condition where the body has trouble controlling blood sugar levels).<br><br>During a review of Resident 26's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 7/4/24, the MDS indicated Resident 26's Brief Interview for Mental Status (BIMS) score was six out of 15 which indicated Resident 26 had severe cognitive impairment (0-7 indicated severe cognitive impairment - [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact).<br><br>During a concurrent interview and record review on 9/11/24 at 3:07 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 26's, Transfer Form, dated 5/24/24 was reviewed. The hospital transfer stated Resident 26 was transferred to the hospital for a urinary tract infection (infection that occurs when bacteria enter the urinary tract and cause irritation or swelling) on 5/24/24. LVN 1 stated only the responsible party and the doctor were notified. LVN 1 stated she was not aware the LTC-Ombudsman needed to be notified of hospital transfers.<br><br>During an interview on 9/11/24 at 03:47 p.m. with the director of staff development (DSD), the DSD stated he was unaware of the need to notify the LTC-Ombudsman for hospital transfers.<br><br>During an interview on 9/13/24 at 10:36 a.m. with the director of nursing (DON), the DON stated the LTC-Ombudsman should have been notified of Resident 26's transfer to the hospital. The DON stated the LTC-Ombudsman should have been notified because the ombudsman was there to help the residents in case issues arise.<br><br>(continued on next page) |

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

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Professional reference titled, CMS Issues Clarification of Notice Requirements to Long-Term Care Ombudsman when Resident is transferred or discharged from Long-Term Care Facility dated 7/24/17, (found at https://hallrender.com/2017/07/24/cms-issues-clarification-of-notice-requirements-to-long-term-care-ombudsman-when-resident-is-transferred-or-discharged-from-long-term-care-facility-review-of-practices-policies-and-procedur/) indicated . On May 12, 2017, the Survey and Certification Group at Centers for Medicare and Medicaid Services (CMS) issued a memorandum, Implementation Issues, Long-Term Care Regulatory Changes . Clarification of Notice before Transfer or Discharge Requirements clarifying the requirements of the Final Rule regarding the timing for providing notice to the State Long-Term Care Ombudsman in the event a resident is transferred or discharged from the long-term care facility. Facilities must immediately review and revise their discharge and transfer notice practices, policies and procedures . Emergency Transfers, when a resident is temporarily transferred on an emergency basis to an acute care facility, notice of the transfer may be provided to the resident and resident representative as soon as practicable . Copies of notices for emergency transfers must also still be sent to the Ombudsman . |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.<br><br>40641<br><br>Based on interview and record review, the facility failed to meet the required timelines for encoding, completion and transmission of Minimum Data Set assessments (MDS-evaluation of cognition, care needs and functional abilities) for one of four sampled residents (Resident 58) when Minimum Data Set Nurse (MDSN) did not complete or transmit discharge MDS assessment for Resident 58.<br><br>This deficient practice resulted in the potential harm of Resident 58's needs upon discharge going unmet.<br><br>Findings:<br><br>During a concurrent interview and record review on 9/12/24 at 9:07 a.m. with the Minimum Data Set Nurse (MDSN), the MDSN reviewed the MDS assessment and submission for Resident 58. The MDSN stated the last assessment for Resident 58 was dated 4/11/24 and it was a quarterly assessment. The MDSN stated Resident 58 was discharged to home on 5/1/24. The MDSN did not find a completed and transmitted MDS discharge assessment tracking for Resident 58 when Resident 58 was discharged to home on 5/1/24. The MDSN stated there should have been a discharge assessment opened and submitted when Resident 58 was discharged home but there was not. The MDSN stated, . I barely started as MDS at that time and did not review MDS schedules . I am not even aware until now there was no discharge assessment opened and submitted . The MDSN stated she follows RAI manual.<br><br>During an interview on 9/13/24 at 2:35 p.m. with the Director of Nursing (DON), the DON stated the MDSN is new and was not sure if MDSN was already working in the facility at the time Resident 58 was discharged to home. The DON stated there should have been an assessment completed and transmitted when Resident 58 was discharged home. The DON stated the MDSN should have reviewed all MDS assessments and was responsible in making sure all assessments are opened and transmitted on a timely basis.<br><br>During an interview on 9/13/24 at 3:40 p.m. with the Administrator (ADM), the ADM stated<br><br>the MDSN is responsible in making sure all MDS assessments were complete and transmitted timely. The ADM stated her expectation was for all MDS assessments complete and accurate.<br><br>During a review of facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, dated 10/23, the P&P indicated, . Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes . 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted . in accordance with current federal and state guideline. 2. Timeframes for completion and submission of assessments is based on the current requirements published . |

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| Sunnyside Conv. Hospital | 2939 S. Peach Avenue<br>Fresno, CA 93725 |

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F 0644

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641

Based on observation, interview and record review, the facility failed to re-evaluate and document current condition for Level I Preadmission screening and Resident Review (PASARR-a federal requirement to ensure residents with mental disorder or intellectual disorder or intellectual disabilities are not inappropriately placed in a nursing home) for one of four sampled residents (Resident 15).

This failure had the potential for Resident 15 to not receive the appropriate services related to his mental disorder, intellectual disabilities or other related cognitive impairment.

Findings:

During an observation on 9/9/24 at 8:15 a.m. in Resident 15's room, Resident 15 was sitting up in bed eating breakfast from breakfast tray placed on top of over the bed table placed across the bed. Resident 15 was appropriately dressed and did not answer any questions asked.

During a review of Resident 15's Admission Record, dated 9/11/24, the Admission Record indicated, Resident 15 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) psychosis (group of symptoms that cause a person to lose touch with reality), depression (persistent low mood or loss of interest in activities) and anxiety (intense, excessive, and persistent worry and fear about everyday situations).

During a review of Resident 15's Order Summary Report, (OSR) dated 9/11/24, the OSR indicated, .Monitor depressive behavior m/b [manifested by] tearfulness every shift related to MAJOR DEPRESSIVE DISORDER . [medication used to treat depression] Oral Tablet 10 MG[milligram-unit of measurement](Paroxetine HCl [hydrochloride])Give 1 [one] tablet by mouth one time a day .

During a review of Resident 15's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 15's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 12 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 15 had moderate cognitive deficit.

During an interview on 9/12/24 at 2:44 p.m. with Business Office Manager (BOM), BOM stated she started working four days ago and working part time as BOM. BOM stated she only goes in the facility in the afternoon after she was done from her other job. BOM stated the only thing she knows about PASARR was the general acute care hospital (GACH) sends a copy to the admitting facility when resident is a new admit. BOM stated the facility updates a PASARR when there is a change in condition.

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

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/13/24 at 10:10 a.m. with the Assistant Director of Nursing (ADON), the ADON stated he had only been working in the facility for six weeks. The ADON stated he was not sure who was responsible in completing PASARR assessment in the facility. ADON stated he only knew GACH completes a PASARR assessment before discharging resident and send a copy to the facility. The ADON stated facility completes the PASARR when resident was admitted from home and if there was a change in condition.<br><br>During a concurrent interview and record review on 9/13/24 at 2:30 p.m. with the Director of Nursing (DON), Resident 15's Level I PASARR dated 4/1/10 was reviewed. Resident 15's PASARR Level I indicated negative, Resident 15 has no diagnosis of mental disorder. DON stated Resident 15 has been prescribed psychotropic medications since admitted in the facility. DON stated Resident 15 has diagnosis of anxiety, depression, dementia and psychosis. DON stated the BOM was responsible in completing PASARR but since the BOM is only working part time and was not familiar with PASARR. DON stated the facility do not currently have a designated person completing PASARR.<br><br>During an interview on 9/13/24 at 3:15 p.m. with the Administrator (ADM), the ADM stated<br><br>the facility do not have a designated person to complete PASARR. The ADM stated her expectation moving forward was to train people to complete the PASARR assessment. The ADM stated PASARR was very important to ensure residents with mental health conditions or illness are referred out in order to receive special treatments needed.<br><br>During a review of facility's policy and procedure (P&P) titled, Admission Criteria dated 3/19, the P&P indicated, . All new admission and readmission are screened for mental disorders (MD) intellectual disabilities (ID) or releated disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process .<br><br>During a review of professional reference titled, Medicaid-certified Skilled Nursing Facilities' (SNFs) Preadmission Screening and Resident Review (PASARR) responsibilities, dated 8/30/23, the SNFs PASARR indicated, .The SNF is required to initiate a Resident Review [RR] be completing Level I Screening when there is a significant change in condition relating to the individual's SMI [serious mental illness] and/or ID[intellectual disability]/DD[developmental disability]/RC[related condition] . The SNF must initiate the RR as a Level I Screening within 72 hours of identification of a significant change in condition or identification of variance between the MDS and Level I screening. |

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608

Based on observation, interview and record review, the facility failed to ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for two of 10 sampled residents (Residents' 53 and 51) when:

1. Resident 53 did not have a care plan for apixaban (anticoagulant - prevent blood clots from forming).

This failure put Resident 53 at risk for harm by not identifying and monitoring for harmful side effects.

2. Resident 51 did not have a care plan for Enhanced Barrier Precaution (EBP-set of infection control practices that uses gowns and gloves during high contact care of residents in nursing homes) status.

This failure placed Resident 51 at a potential risk for her needs to go unmet while under enhanced barrier precaution.

Findings:

1. During a review of Resident 53's Admission Record (AR), (a document containing pertinent resident profile information) dated 9/15/24, the AR indicated, Resident 53 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease (ESRD - the final, permanent stage of chronic kidney disease, where kidney function has declined to the point that the kidneys can no longer function on their own), Acute Pulmonary Edema (a build up fluid in the lungs that makes it hard to breathe), Atrial Fibrillation (AFIB - irregular heartbeat that occurs when the heart's upper chambers beat abnormally fast and out of sync with the lower chambers of the heart), and Depression (a mental health condition characterized by a persistent low mood and loss of interest in activities).

During a review of Resident 53's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 53's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 5 out of 15 which indicated Resident 53 had severe cognitive deficit.

During a review of Resident 53's Order Summary Report (OSP), (a report of all orders for resident while in facility), dated 9/13/24, the OSP indicated Resident 53 had an order for apixaban 5 mg tablet twice per day to treat AFIB.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555352 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/13/2024 |
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| NAME OF PROVIDER OR SUPPLIER Sunnyside Conv. Hospital | | STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. Peach Avenue Fresno, CA 93725 | |

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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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 9/12/24 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated, she looked through Resident 53's Electronic Medical Record (EMR) dated 9/12/24 was reviewed. The EMT was unable to locate a care plan for Resident 53's apixaban an anticoagulant medication to prevent blood clots from forming. LVN 4 stated, a care plan is required for all residents taking anticoagulants.<br><br>During a concurrent interview and record review on 9/12/24 at 2:00 p.m. with the Minimum Data Set (MDS), Resident 53's EMR dated 9/12/24 was reviewed. The MDS stated she was unable to find a care plan in Resident 53's EMR. The MDS stated, per facility policy, when an anticoagulant is prescribed an anticoagulant a care plan to monitor for possible life-threatening side effects.<br><br>During an interview on 9/12/24 at 2:57 p.m. with the Director of Nurses (DON), the DON stated, Resident 53 does not have an anticoagulant care plan. Resident should have a care plan to monitor for adverse reactions.<br><br>During an interview on 9/13/24 at 4:59 p.m. with the Administrator (ADM), the ADM stated, . anticoagulants need to have a care plan, the care plan provides staff instructions to care for residents .<br><br>During a review of the facility's policy and procedure (P&P), titled Resident Participation - Assessment Care Plans dated 2001, indicated, .Resident assessments are begun on the first day of admission . a comprehensive care is developed within seven (7) days of completing the resident assessment .<br><br>40641<br><br>Findings:<br><br>2. During a concurrent observation and interview on 9/9/24 at 8:18 a.m. Resident 51 was observed lying in a bariatric bed, appropriately dressed and covered. Resident 51 stated she was new in the facility and used to live at home. Resident 51 stated she did not have any complaints, staff are helping her with all her Activities of Daily Living (ADL-tasks people perform on a daily basis to care for themselves) needs.<br><br>During a review of Resident 51's Admission Record, dated 9/11/24, the Admission Record indicated, Resident 51 was admitted to the facility on [DATE] with diagnoses which included heart failure, morbid (extreme) obesity and osteoarthritis (chronic[long lasting] condition that breakdown cartilage and bone in the joints causing pain, stiffness, and swelling).<br><br>During a review of Resident 51's Minimum Data Set (MDS- an assessment tool used to identify resident cognitive[pertaining to reasoning, memory and judgement] and physical functional level), assessment dated [DATE], indicated Resident 51's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 13 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 51 had no cognitive deficit.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 9/11/24 at 1:40 p.m. with the Infection Preventionist (IP), the IP reviewed Resident 51's clinical record and stated Resident 51 was placed on EBP since admission. The IP stated she placed Resident 51 on EBP because of skin issues. The IP stated she did not find a care plan for EBP and there should have been. The IP stated she was responsible in ensuring a care plan was initiated to direct staff on how to care for Resident 51.<br><br>During an interview on 9/12/24 at 11:35 a.m. with Registered Nurse Supervisor (RNS), RNS stated the IP was responsible in creating a care plan for all infection control issues including EBP. RNS stated care plans are important because it directs the nursing staff on how to take care of residents.<br><br>During an interview on 9/13/24 at 2:05 p.m. with the Director of Nursing (DON), the DON stated care plans are the responsibilities of all licensed nursing staff. DON stated IP was responsible in ensuring there was a care plan initiated for all infection control issues including EBP. DON stated her expectation was to make sure care plans was initiated and individualized to each resident's needs.<br><br>During a review of facility\s policy and procedure (P&P) titled, Resident Participation-Assessment/Care Plans, dated 2/21, the P&P indicated, . A comprehensive care plan is developed within seven (7) days . |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641<br><br>Based on observation, interview and record review, the facility failed to meet professional standards of practice for two of 11 sampled residents (Resident 27 and Resident 44) when<br><br>1. A medicine cup with seven tablets was left on top of Resident 27's breakfast tray.<br><br>This failure had the potential for Resident 27 to not received the prescribed medications and for other residents to have access to the medications which could lead to serious health condition.<br><br>2. Resident 44 physicians order for padded siderails were not followed.<br><br>This failure had the potential to cause injury to Resident 44 if he hit the side rails.<br><br>Findings:<br><br>1. During a concurrent observation and interview on 9/9/24 at 8:20 a.m. in Resident 27's room, Resident 27 was sitting up in his wheelchair at bedside eating breakfast. Resident 27 was dressed appropriately. On the breakfast tray was a medication cup with seven tablets in it. Resident 27 stated the licensed nurse left the medication cup with the medications for him to take. Resident 27 stated nurses usually just leave his medications on top of his bedside table to take.<br><br>During a review of Resident 27's Admission Record, (AR) dated 9/11/24, the AR indicated Resident 27 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (complete loss of strength or paralysis on one side of the body) and hemiparesis (mild loss of strength on one side of the body) and diabetes (high blood sugar level in the blood).<br><br>During a review of Resident 27's Minimum Data Set (MDS- resident assessment tool use to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 27's Brief Interview of Mental Status assessment (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 27 had no cognitive deficit.<br><br>During an interview on 9/9/24, at 8:33 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated she was the night nurse and was responsible for Resident 27. LVN 4 stated medications are not to be left at bedside unattended because it was unsafe, other residents could get in and take medications or staff could throw medications away. LVN 4 stated Resident 27 has a care plan and assessment he can have his medications at bedside. LVN 4 stated she left the medication cup with medications on top of Resident 27's bedside table so he could take after he eats his breakfast. LVN 4 stated she sometimes goes back to make sure Resident 27 took his medications.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 9/9/24 at 10:05 a.m. with Registered Nurse Supervisor (RNS), RNS reviewed Resident 27's clinical record titled care plan dated 8/22/24 and medication self-administration safety screen dated 8/22/24 and stated Resident 27 was assessed for the use of a topical medication used for temporary relief from muscle and joint pain not for oral medications. RNS stated the practice was to never leave medications at the bedside unattended. RNS stated other residents could go in the room and take the medications or the resident may not even take the medications. RNS stated staff could accidentally throw away the medications.<br><br>During an interview on 9/11/24 at 2:40 p.m. with LVN 2, he stated the practice was to never leave medications at bedside unattended. LVN 2 stated nurse administering medications has to make sure resident takes the medication before leaving resident's room. LVN 2 stated other residents could go into a another residents room and take the medication themselves which could potentially lead to serious health condition. LVN 2 stated resident could also hoard medications and or distribute to other residents which could potentially create bigger problem.<br><br>During an interview on 9/13/24 at 2:25 p.m. with the Director of Nursing (DON), DON stated her expectation was to never leave any medications at bedside and unattended. DON stated nurses administering medications should not leave a resident's bedside until medication was swallowed. DON stated it was more than one medication that was left at bedside Resident 27 and other resident could go in Resident 27's room and take medications themselves which could result in serious health condition. DON stated staff or resident could throw medication away resulting in resident not taking medications which could result to his condition not improving or getting worse.<br><br>During a review of facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/23, the P&P indicated, . The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner . items are not left unattended .<br><br>48424<br><br>2. During a review of Residents 44's admission record (AR- a document which provides resident contact details, a brief medical history level of functioning, preferences, and wishes), dated 9/12/24, the AR indicated Resident 44's admitting diagnoses included the following: hemiplegia (a condition which causes partial or complete weakness or inability to move on one side of the body), epilepsy (a condition characterized by a sudden, uncontrolled burst of electrical activity in the brain which can cause uncontrolled body movements), anxiety disorder(a feeling of fear, and uneasiness).<br><br>During an observation on 9/9/24 at 9:57 a.m. in Resident 44's room, Resident 44 had his left and right bedrails raised with no padding on either rail.<br><br>During an observation on 9/11/24 at 10:48 a.m. in Resident 44's room, Resident 44 had his left and right bedrails raised with no padding on either rail.<br><br>During a concurrent observation and interview on 9/11/24 at 3:03 p.m. with Certified Nursing Assistant (CNA) 4 in Resident 44's room, Resident 44 had his left and right bedrails raised with no padding on either rail. CNA 4 stated Resident 44 should have had his bedrails padded if it was ordered. CNA 4 stated it was important to follow orders for padded rails because Resident 44 may have hurt himself if he had a seizure (condition characterized by sudden and uncontrolled movements) or if he moved his arms and legs around a lot.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 9/12/24 at 9:40 a.m. CNA 5 in Resident 44's room, Resident 44 had his left and right bedrails raised with no padding on either rail. CNA 5 stated Resident 44 should have had padding on his side rail. CNA 5 stated padding the side rail was important in order to protect Resident 44 if he moved his limbs and hit the rail.<br><br>During an interview on 9/12/24 at 11:34 a.m. with CNA 2, CNA 2 stated Resident 44 had padded side rails in the past. CNA 2 stated Resident 44 needed to have his side rails padded at all times. CNA 2 stated if there was a doctor's order for padded side rails than staff needed to follow it. CNA 2 stated nurses were supposed to let CNAs know when resident bedrails needed to be padded. CNA 2 stated other CNAs were also supposed to pass down any information regarding bedrails during shift change report. CNA 2 stated as soon as a CNA or nurse noticed there was no padding on the siderails they should have reported it to a nurse. CNA 2 stated it was important to ensure the bedrails were padded because if Resident 44 moved his arms and legs excessively he could have hurt himself on the unpadded side rails.<br><br>During a concurrent interview and record review on 9/12 24 at 1:38 p.m. with Licensed Vocational Nurse (LVN) (2) , Resident 44's 'Order Summary Report, dated 9/12/24, was reviewed. The Order Summary Report indicated, . Resident [44] to have full padded side rails [on both sides] for safety [related to] seizure condition. Side rails to be up when resident is in bed and may be released during [activities of daily living] . LVN 2 stated Resident 44 needed to have his bedrails padded. LVN 2 stated bedrail orders were communicated to the other nurses during report. LVN 2 stated bedrail orders were communicated to CNAs by nurses and when there was an new order for a resident. LVN 2 stated if his bedrails were not padded and Resident 44 had a seizure he could have hurt himself.<br><br>During an interview on 9/13/24 at 11:12 a.m. with the director of nursing (DON), the DON stated Resident 44 should have had his siderails padded at all times when he was in bed. The DON stated Resident 44 moved his body a lot and could have gotten hurt if he hit himself against the side rail.<br><br>During an interview on 9/13/24 at 11:12 a.m. with the Director of Staff Development (DSD) the DSD stated CNAs and nurses should have reported to the charge nurse if they noticed Resident 44's siderails were not padded. DSD stated the nurses could have also padded the rails if they saw they were missing.<br><br>During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, dated 8/22 indicated . 2. Consideration is given to the resident's safety, medial conditions, comfort, and freedom of movement . 1. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury . |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>48424<br><br>Based on observation, interview, and record review, the facility failed to assess one of seven residents (Resident 59) for risk of entrapment (caught, trapped, or entangled in the space in or about the bed and side rail) from bed rails (adjustable metal or rigid plastic bars that attach to the bed), obtain informed consent (form signed by resident or family explaining the risks of side rail use), obtain physician order with indication for use, and create care plans prior to the use of bed rails when Resident 59 had his right bed rail raised up.<br><br>These failures had the potential to place Resident 59 at risk for decreased freedom of movement, entrapment and/or injury.<br><br>Findings:<br><br>During a review of Resident 59's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment, dated 8/14/24, indicated Resident 59's Brief Interview for Mental Status (BIMS - screening tool used to assess resident cognitive level) score was 11 out of 15 indicating Resident 59 had moderate cognitive impairment (0-7 indicated severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 cognitively intact).<br><br>During a concurrent observation and interview on 9/9/24 at 9:19 a.m. with Resident 59 in Resident 59's room, Resident 59 had his right side rail raised. Resident 59 stated he used the side rail to reposition himself.<br><br>During a concurrent observation and interview on 9/9/24 at 9:51 a.m. with certified nursing assistant (CNA) 3 in Resident 59's room, Resident 59 was lying in bed with his right side rail raised. CNA 3 stated Resident 59 liked to use the side rail to place his urinal there and to help him move.<br><br>During an observation on 9/10/24 at 12:30 p.m. in Resident 59's room, Resident 59 was lying in bed and had his right side rail raised.<br><br>During an observation on 9/11/24 at 9:18 a.m. in Resident 59's room, Resident 59 was lying in bed and had his right side rail raised.<br><br>During an interview on 9/12/24 at 11:34 a.m. with CNA 2, CNA 2 stated Resident 59 used his right side rail for mobility and to help him reposition. CNA 2 stated staff were aware there needed to be a physician's order before any resident could use side rails. CNA 2 stated obtaining physician orders was needed prior to using side rails so staff were aware of the reason a resident needed to use them and to ensure the resident remained safe from improper use.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 9/12/24 at 1:47 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 59's clinical record, undated, was reviewed. The clinical record indicated there was no physician's orders, no care planning, no safety evaluation, and no consents obtained for the use of side rails. LVN 2 stated Resident 59 should not have been using siderails unless physician's orders, care planning, safety evaluation, and consents were put in place. LVN 2 stated it was important to do all the required forms for side rails because it was for resident safety.<br><br>During a concurrent observation and interview on 9/12/24 at 2:25 p.m. with LVN 2 in Resident 59's room, Resident 59's right side rail was raised. LVN 2 stated staff should have confirmed, care planning, safety assessment, consents, and physician's orders were in place before raising Resident 59's side rail.<br><br>During an interview on 9/13/24 at 10:18 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 59 did not use any side rails when he was admitted . The MDSC stated staff members should have noticed he was using a side rail and ensured a physician order was in place for the use of the side rail.<br><br>During an interview on 9/13/24 at 11:12 a.m. with the Director of Nursing (DON), the DON stated all residents needed a physician's order, care planning, safety evaluation, and consents prior to using side rails.<br><br>During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, dated 8/22, indicated, . the use of bed rails is prohibited unless the criteria for use of bed rails have been met .3. bed frames, mattresses and bed rails are checked for compatibility and size prior to use . bed rail and matters will leave no gap wide enough to entrap a resident's head or body . the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited, unless the criteria for use of bed rails have been met, including attempts to user alternatives, interdisciplinary evaluation , resident assessment and informed consent . |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>48430<br><br>Based on observation, interview and record review, the facility failed to provide acetylsalicylic acid 325 mg (ASA-a medication that reduces pain, fever, inflammation, and blood clots [mg-milligrams a unit of measurement]) for one of one sampled resident (Resident 1) who has an order for acetylsalicylic acid 325 mg when the facility ran out of the medication.<br><br>This failure cause Resident 1 to miss a scheduled dose of medication ordered to prevent blood clots (gel like clump of blood that can form inside the veins and restrict blood flow) .<br><br>Findings:<br><br>During a concurrent observation and interview on 9/11/24 at 8:17 a.m. with (Licensed Vocational Nurse) LVN 2, in front of Resident 1's room, Resident 1's acetylsalicylic acid 325 mg was missing. LVN 2 stated the medication was not available.<br><br>During an interview on 9/11/24 at 8:36 a.m. with the (Director of Nursing) DON the DON stated, the (Associate Director of Nursing) ADON was sent to get the medication from a local pharmacy.<br><br>During an interview on 9/11/24 at 4:27 p.m. with the Skilled Nursing Pharmacy Consultant (SN PC) the SN PC stated, re-ordering of house supply medications was the responsibility of the facility specifically the nurses. The PC states, once nurses see the medications running low, they should have ordered before running out. The PC states, aspirin is used as a blood thinner to prevent a clotting stroke (blood clot is a mass of blood blocks the flow of blood and oxygen to the brain).<br><br>During an interview on 9/11/24 at 4:38 p.m. with the ADON, the ADON stated, either the ADON or RN (Registered Nurse) supervisor is the one responsible for ordering the over-the-counter medications for the facility supply. The ADON stated, when nurses see that medications are running low, they should notify either the RN Supervisor, ADON, or DON. The ADON stated, one full bottle of a medication should always be available before the supply runs out. The ADON stated, if the aspirin ran out, there could have been a potential for Resident 1 to develop a blood clot. The ADON stated, if a resident does not receive medication because they were not available that is not following the current treatment plan of for the resident.<br><br>During a review of Resident 1's Medication Administration Record (MAR), dated 9/11/2024, the MAR indicated, [acetylsalicylic acid] EC Tablet Delayed Release 325 MG . Give 1 tablet by mouth one time a day related to OCCLUSION (block) AND STENOSIS (narrowing) OF UNSPECIFIED CEREBRAL ARTERY (arteries that supply blood to the brain ).<br><br>During a review of the facility's policy and procedure titled, Medication and Treatment Orders dated 2001, indicated, Drugs .must be refilled must reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. |

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430

Based on observation, interview and record review, the facility failed to ensure medications were stored safely when: one of two medication carts were properly stored when :

1. medication were not labeled in accordance with accepted professional principles for 11 out of 11 residents (Resident 2, Resident 6, Resident 14, Resident 31, Resident 32, Resident 36, Resident 44, Resident 51, Resident 54, Resident 56, Resident 57 ) when medications that are administered via an inhaler (a medical device used for delivering medicines into the lungs through the work of a person's breathing ) to treat difficulty breathing were not labeled with use by dates or the medication expiration dates.

This failure had the potential for residents to being given expired medications which could lead to difficulty breathing due to reduced efficacy of the medications.

2. One of two medications carts was left in the hall outside of resident room [ROOM NUMBER], with keys on top of the medication cart.

This failure had the potential for residents, visitors, and other staff to access the medications take medication not prescribed to themin the medication cart which could lead to serious medical conditions and could lead to potential drug diversion.

Findings:

1. During an observation and interview on 9/11/24 at 09:29 a.m. with (Licensed Vocational Nurse) LVN 2, of the Med Cart for station one, LVN 2 validated there was no expiration date written on Resident 2, 6, 32, 51, 56 and 57's box of the inhaler or medication inhaler. LVN 2 stated, these medications did not have expiration dates written on the box.

During an observation and interview on 9/11/24 at 10:20 a.m. with LVN 1, an of the Med Cart for station two LVN 1 validated there was no expiration date written on Resident 14, 31, 36, 44, 54, 57's box of the inhaler or medication device. LVN 1 stated, she doesn't know if expiration dates should have been written on the box or the actual medication inhaler.

During an interview on 9/11/24 at 11:18 a.m. with the Director of Nursing (DON), the DON stated, there needs to be an open date and a use by date written on the box. The DON stated, if there are no clear expiration or use by date written on the box or the medication inhaler itself, nurses could possibly give medications that are expired.

During an interview on 9/11/24 at 2:46 p.m. with the Skilled Nursing Pharmacy Consultant (SN PC), SN PC stated, labeling a best used by date on the box is best practice to ensure the medications are effective. SN PC stated, if the medications are used beyond the use date, it could be subtherapeutic (a dose of a drug that does not achieve a particular therapeutic effect) and cause harm instead of benefits.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555352 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/13/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Sunnyside Conv. Hospital | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure titled, Medication Labeling and Storage dated February 2023, indicated, The medication label includes, at a minimum .expiration date.<br><br>41608<br><br>2. During an observation on 9/9/24 at 12:23 p.m. in the hall outside of room [ROOM NUMBER], a medication cart was left unattended with keys on top of the medication cart.<br><br>During a concurrent observation and interview on 9/9/24 p.m. at 12:26 p.m. with Licensed Vocational Nurse (LVN) 2, in the hall outside of room [ROOM NUMBER], the unattended medication cart was observed with keys on top of the medication cart. LVN 2 stated, he should not have left the keys on top of the medication cart. LVN 2 stated, . a resident, visitor, or other staff member could get access and take the keys open the cart and injure themselves or another Resident .<br><br>During an interview on 9/9/24 at 12:38 p.m. with the Assistant Director of Nurses (ADON), the ADON stated, the keys should not have been left on top of the unattended medication cart. The ADON stated, the resident medications should be locked at all times to prevent unauthorized persons from accessing resident medications.<br><br>During an interview on 9/12/24 at 10:06 a.m. with the Administrator (ADM), the ADM stated, the keys should not be left on top of the medication cart. The ADM stated, residents or visitors could get into the unattended medication cart and take medications not prescribed to them possibly resulting in serious harm.<br><br>During a review of the facility's policy and procedure (P&P), tiled Medication Labeling and Storage dated 2/2023, indicated, The facility stores all medications and biologicals in locked compartments . Only authorized personnel have access to keys . |

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| Sunnyside Conv. Hospital | 2939 S. Peach Avenue<br>Fresno, CA 93725 |

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F 0802

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.

40641

Based on observation, interviews and record review, the facility failed to ensure dietary cook (DC) 1 was competent to carry out the functions of food and nutrition services safely and effectively when:

1. DC 1 served to much food for a large portion size diet for Residents' 15, 48 and 50.

2. DC 1 did not fortify food for the fortified diets for Residents' 15, 18 and 50.

3. DC 1 did not follow pureed food recipe for Residents' 11, 18, 44, 53 and 214.

4. DC 1 did not checked the temperature for pureed foods prior to serving.

5. Kitchen did not have enough chile relleno casserole to serve to Residents' 17, 22 and 31.

These failures resulted in Residents' 15, 18, 50, 11, 44, 53, 214, 17, 22 and 31's diet orders and the facility menu to not be followed.

Findings:

1. During observation on 9/10/24 at 12:32 p.m. during tray line in the kitchen, Dietary [NAME] (DC) 1 observed plating food for large portion diet. DC 1 placed one and one half serving of main dish (chile relleno casserole) in the plates of large portion diet.

During a concurrent interview and record review on 9/10/24 at 3:15 p.m. with Dietary Service Supervisor (DSS), DSS stated the spreadsheet indicated large portions get one serving of main dish unless the diet slip specified to give two portions of proteins. DSS stated CK 1 did not follow the spreadsheet. The DSS stated the spreadsheet indicated to give extra serving of vegetables and not the main dish.

During an interview on 9/11/24 at 9:24 a.m. with DC 1, DC 1 stated he served one- and one-half portion of chile relleno casserole for the large portion diet order. DC 1 stated it was more than it was recommended in the spreadsheet. DC 1 stated he was used to serving extra protein when the diet slip indicated large portion. DC 1 stated he should have read and followed the spreadsheet.

During a review of facility's policy and procedure (P&P) titled, Small, Large, and Double Potions, dated 1/1/17, the P&P indicated, . Menus shall be planned with consideration of cultural background and food habits of patients (residents) .

2. During an observation on 9/10/24 at 12:15 p.m. during tray line, Dietary [NAME] (DC) 1 was observed preparing foods for Residents on fortified diet. DC 1did not add additional butter to vegetables to fortify food.

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 9/10/24 at 3:15 p.m. with Dietary Service Supervisor (DSS), DSS stated they have three residents currently on fortified diet. DSS stated, . The spreadsheet indicated to add butter to the vegetables to fortify the food . The DSS stated residents on fortified diet needed the extra nutrients and the cook did not add extra butter to the vegetable for residents' on fortified diets. The DSS stated (Dietary Cook) DC 1 did not follow the spreadsheet menu.<br><br>During an interview on 9/11/24 at 9:20 a.m. with DC 1, DC 1 stated, . I already put butter in the vegetables, so I did not put extra butter for residents on fortified diet . DC 1 stated he did not follow the diet menu for residents on fortified diet. DC 1 stated it was important to follow their diet because they needed the extra nutrients.<br><br>During an interview on 9/11/24 at 4:45 p.m. with Registered Dietitian (RD), RD stated residents on fortified diet have higher nutrient demands. RD stated cook needed to follow the standardize recipe to meet resident's needs.<br><br>During an interview on 9/13/24 at 3:30 p.m. with the Administrator (ADM), the ADM stated DSS was responsible in ensuring the kitchen staff are fully trained with their job duties and responsibilities. The ADM stated her expectation was to make sure the spreadsheet was followed.<br><br>During a review of the facility's policy and procedure (P&P) titled, Fortified Food Program, dated 1/1/17, the P&P indicated, . To provide nutrient dense foods for residents requiring extra protein and calories who are unable to consume adequate amounts of food . Fortified diet follows the pattern in the diet manual with a minimum of two fortified items per meal .<br><br>3. During observation on 9/10/24 at 12:35 p.m. in the kitchen during tray line, Dietary [NAME] (DC) 1 was observed preparing food for residents on pureed diet. DC 1 did not add smooth Mexican tomato sauce to pureed food. DC 1 did not follow the spreadsheet menu for Residents' 11, 18, 44, 53 and 214's pureed diet order.<br><br>During an interview on 9/11/24 at 9:20 a.m. with DC 1, DC 1 stated it was his fault he did not follow the spreadsheet menu, he did not add tomato sauce to pureed diet as indicated in the spreadsheet. DC 1 stated the tomato sauce could have enhanced the flavor of the pureed foods.<br><br>During an interview on 9/10/24 at 3:15 p.m. with the Dietary Service Supervisor (DSS), DSS stated, . I am not sure why he (DC 1) did not add the tomato sauce on the pureed diet, he prepared it . DSS stated DC 1 should have followed the spreadsheet menu.<br><br>During a review of facility's policy and procedure (P&P) titled, Texture Modified Diet, dated 1/1/17, the P&P indicated, .Each resident receives and the facility provides - Food prepared in a form designed to meet individual needs .<br><br>4. During observation on 9/10/24, at 12:01 p.m. during tray line in the kitchen, Dietary [NAME] (DC) 1 was observed checking temperatures of food on the steam table except the pureed foods. DC 1 did not checked the temperature of pureed food prior to serving to residents.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a concurrent interview and record review on 9/10/24 at 3:27 a.m. with Dietary Service Supervisor (DSS), DSS stated she was not sure why DC 1 did not checked the temperature of the pureed food. DSS stated all food's temperature needed to be checked prior to serving to residents to make sure it was safe to serve to residents.<br><br>During an interview on 9/11/24 at 9:15 a.m. with DC 1, DC 1 stated he did not check the temperature of pureed foods prior to serving to residents. DC 1 stated he should have checked the temperature to make sure it was safe to served to residents.<br><br>During an interview on 9/11/24 at 4:39 p.m. with Registered Dietitian (RD), the RD stated temperatures of foods have to checked prior to serving to eliminate or minimize food borne from happening. RD stated, .not checking the temperature was not acceptable, more risk for food borne illness to occur when temp is in danger zone .<br><br>During a review of facility's policy and procedure (P&P) titled, Job Description-Cook, dated 1/1/17, the P&P indicated, . Serves food during tray line and maintains area utilizing high standards of sanitation . Exercise judgement and initiative in preparing food, and maintain efficient standards of operation .<br><br>professional reference https://www.fsis.usda.gov/food-safety/safe-food-handling-and-preparation/food-safety-basics/kitchen-thermometers#:~:text=Why%20Use%20a%20Food%20Thermometer, may%20be%20in%20the%20food, .It is essential to use a food thermometer when cooking meat, poultry, and egg products to prevent undercooking, verify that food has reached a safe minimum internal temperature, and consequently, prevent food borne illness .Using a food thermometer is the only reliable way to ensure safety and to determine desired doneness of meat, poultry, and egg products. To be safe, these foods must be cooked to a safe minimum internal temperature to destroy any harmful microorganisms that may be in the food .A food thermometer should also be used to ensure that cooked food is held at safe temperatures until served. Cold foods should be held at 40 F or below. Hot food should be kept hot at 140 F or above .<br><br>5. During a concurrent observation and interview on 9/10/24 at 12:30 p.m. during tray line in the kitchen, Dietary [NAME] (DC) 1 was observed putting alternate food (beef, bean and cheese burrito) into Residents' 17, 22 and 31 food. DC 1 stated there was not enough chile relleno casserole to give to last three residents (Resident's 17, 22 and 31) so he gave them burrito which was an alternate. DC 1 stated alternate was usually given when residents requested or they did not like the main dish.<br><br>During an interview on 9/10/24 at 3:05 p.m. with the Dietary Service Supervisor (DSS), the DSS stated it was the first time the kitchen did not have enough food to serve all their residents. Her expectation was to have enough food to serve all the residents in the facility. DSS stated it was not right to give Residents' 17, 22 and 31 the alternate because they did not request for the alternate.<br><br>During a phone interview on 9/11/24 at 4: 41 p.m. with the Registered Dietitian (RD), RD stated DSS was responsible in ordering food supplies and was not sure how they ran out of the main dish if the menu was followed. RD stated alternate food is for residents that did not like the menu and when food was not enough. RD stated it was not an ideal situation to give the alternate food but it was better than not having any food served to residents.<br><br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of facility's policy and procedure (P&P) titled, Alternates on the Menu & Meal Substitution, dated 1/1/17, the P&P indicated, . Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice .These alternates are for residents to choose from when they choose not to eat the scheduled menu item .<br><br>During a review of facility's document titled, Daily Cook's Menu, undated, the Daily Cook's Menu indicated, . Dates served: 9/10, 10/18 . Recipe Name: Chile Relleno's Tort/casserole . Portion size: 2 x4/2, Regular NAS [no added salt]: X, Small: X, Large: X . Sauce, Smooth Mexican Tomato . Pureed: X .<br><br>During a review of Facility's policy and procedure (P&P) titled, Job Description-Cook, the P&P indicated . Prepares food for residents using menu and standardized recipes . Follows menu and recipes trying to minimize leftovers . Maintain high standards of quality food production and portion control . |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>40641<br><br>FACILITY<br><br>Based on observation, interview and record review, the facility failed to ensure food served met the daily nutritional needs for seven of 54 sampled residents (Residents' 15, 48, 50, 18, 17, 22, 31) when:<br><br>1. Residents on large portion diets (Residents 15, 48 and 50) were served more than the required portion size of the chile relleno casserole based on the facility's menu.<br><br>This failure had the potential to result in Residents 15, 48 and 50 to receive more than the recommended daily caloric intake based on the Medical Doctor's order and Registered Dietitian's (RD) assessment of residents' nutritional dietary needs and the potential for unintended weight gain.<br><br>2. Residents' 15, 18 and 50 did not received fortified (foods with nutrients added to help boost nutritional value and benefit health) diet as ordered by physician.<br><br>This failure had the potential to result in Residents' 15,18 and 50 to not receive the additional calories recommended based on resident nutritional dietary needs.<br><br>3. Residents' 17, 22 and 31 received alternate food on 9/10/24 due to not enough chile relleno casserole.<br><br>This failure resulted in Residents' 17, 22 and 31's right to not receive the same food distributed to other residents in the facility.<br><br>Findings:<br><br>1. During a review of facility's document titled, Diet Type Report, dated 9/9/24, the Diet Type Report indicated, . Resident Name: [Resident 15] . Additional Directions: large portions and fortified foods w/[with] meals . Resident Name: [Resident 48] . Additional Directions: Large Portions. Scoop plate . Resident Name: [50] . Diet type: Large Portion .<br><br>During a tray-line observation on 9/10/24 at 12 p.m. the Dietary [NAME] (DC) 1 served one and one half slices (2X4 [two inches by four inches]) of chile rellenos casserole instead of one slice to residents with order for large portions diets.<br><br>During an interview on 9/11/24 at 9:13 a.m. with DC 1, DC 1 stated he served residents with large portion diet order more than what was indicated in the spreadsheet menu. DC 1 stated he gave one and one half portion of the chile relleno casserole instead of one portion. DC 1 stated the extra portion was supposed to be the vegetables.<br><br>During an interview on 9/11/24 at 4:45 p.m. with Registered Dietitian (RD), the RD stated<br><br>(continued on next page) |

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

his expectation was to follow the diet order for residents. RD stated the menu and spreadsheet should have been followed when it comes to portion sizes. RD stated residents on large portion diet received more than the required nutrients they need which could lead to weight gain or higher lab level.

During a review of facility's policy and procedure (P&P) titled, Small, Large, and Double Potions, dated 1/1/17, the P&P indicated, . Menus shall be planned with consideration of cultural background and food habits of patients (residents) .

2. During a review of facility's document titled, Diet Type Report, dated 9/9/24, the Diet Type Report indicated, . Resident Name: [Resident 15] . Additional Directions: large portions and fortified foods w/[with] meals . Resident Name: [Resident 18] . Additional Directions: Fortified . Double Portions for Breakfast and Lunch . Resident Name: [50] . Diet type: Large Portion . Fortified Diet, bean burritos .

During an observation on 9/10/24 at 12:10 p.m. during tray line in the kitchen, Dietary [NAME] (DC) 1 was observed preparing foods for residents on fortified diet. DC 1 did not add extra butter on the vegetables to fortify the diet.

During a concurrent interview and record review on 9/10/24 at 3:05 p.m. with Dietary Service Supervisor (DSS), spreadsheet for 9/10/24 was reviewed and DSS stated extra butter was supposed to be added to the vegetables for the residents on fortified diet because they needed the extra nutrients. DSS stated DC 1 should have added extra melted butter to the vegetables and he did not. DSS stated DC 1 did not follow the fortified diet order for residents on fortified diet. DSS stated her expectation was to follow menu and spreadsheet.

During an interview on 9/11/24 at 9:16 a.m. with DC 1, he stated he did not follow the diet order for residents on fortified diet. DC 1 stated he did not put extra melted butter on the vegetables for the fortified diet because there was already butter added when he prepared the vegetables. DC 1 stated residents on fortified diet needed the extra nutrients and he did not add the extra melted butter to fortify their diet.

During an interview on 9/13/24 at 3:30 p.m. with the Administrator (ADM), the ADM stated DSM was responsible in ensuring the kitchen staff are fully trained with their job duties and responsibilities. The ADM stated her expectation was to make sure the spreadsheet was followed.

During a review of the facility's policy and procedure (P&P) titled, Fortified Food Program, dated 1/1/17, the P&P indicated, . To provide nutrient dense foods for residents requiring extra protein and calories who are unable to consume adequate amounts of food . Fortified diet follows the pattern in the diet manual with a minimum of two fortified items per meal .

3. During a review of facility's document titles, Diet Type Report, dated 9/19/24, the Diet Type Report indicated, .Resident Name: [Resident 17] Diet Texture: Regular . [Resident 22] . Mechanical Soft . [Resident 31] . Mechanical Soft .

During concurrent observation and interview on 9/11/24 at 12:25 p.m. during tray line in the kitchen, there was not enough main dish of chile casserole for Residents' 17, 22 and 31. DC 1 observed preparing plates for Residents' 17, 22 and 31 and added beef, bean, and cheese burrito in their plates instead of the chile rellano casserole. DC 1 stated there was not enough chile rellano casserole.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 555352 | A. Building<br>B. Wing | 09/13/2024 |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 9/11/24 at 9:13 a.m. with DC 1, he stated it was the first time they did not have enough food (Chile Relleno) to serve all residents. DC 1 stated it was not an acceptable practice to replace main dish with alternate food when residents did not request. DC 1 stated the practice was to substitute food only upon resident request. DC 1 stated the three residents were given the alternates without requesting because the kitchen did not have enough of the main dish to serve.<br><br>During a concurrent interview and record review on 9/12/24 at 1:55 p.m. with Dietary Service Supervisor (DSS), DSS stated it was the first time it happened they did not have enough food (Chile Relleno Casserole) for all residents. DSS stated the expectation was to have enough food to serve all residents without using the alternate. DSM stated it was not right to give alternate to residents when they did not request to have the alternate.<br><br>During an interview on 9/11/24 at 4: 41 p.m. with the Registered Dietitian (RD), RD stated DSS was responsible in ordering food supplies and was not sure how they ran out of the main dish if the menu was followed. RD stated alternate food is for residents that did not like the menu and when food was not enough. RD stated it was not an ideal situation to give the alternate food but it was better than not having any food served to residents.<br><br>During a review of facility's policy and procedure titled, Alternates on the Menu & Meal Substitution, dated 1/1/17, the P&P indicated, . Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice .These alternates are for residents to choose from when they choose not to eat the scheduled menu item . |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>40641<br><br>Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation and storage practices were followed in for 54 out of 62 resident when the two-compartment prep sink in the kitchen did not have an air gap.<br><br>This failure had the potential to cause food-borne illness (illnes caused by consuming contaminated foods or beverages) to the facility's fragile residents.<br><br>Findings:<br><br>1. During a concurrent observation and interview on 9/9/24 at 7:20 a.m. with Dietary Service Supervisor (DSS) in the kitchen in front of the two-compartment sink, DSS stated the two-compartment sink did not have an air gap (an air gap refers to fixture that provides back-flow prevention). DSS stated the dietary staff used the two compartments sink as a prep sink (sink used to washed produce).<br><br>During an interview on 9/10/24 at 3:08 p.m. with the Maintenance Supervisor (MS), he stated he was aware the two-compartment sink did not have an air gap.<br><br>During an interview on 9/10/24 at 3:35 p.m. with DSS, the DSS stated she was aware there was no air gap under the two-compartment sink/food prep sink because it was already in the previous survey result. The DSS stated the facility tried to install air gap after the last survey but it did not work out.<br><br>During an interview on 9/11/24 at 4:45 p.m. with Registered Dietitian (RD), the RD stated the air gap was necessary to ensure no gasses or bacteria from the outside come through the pipeline to the prep sink area, which could lead to bacteria getting into the food. RD stated this could lead to residents getting ill.<br><br>During a review of facility's policy and procedure (P&P) titled, Backflow Preventers, dated 1/1/17, the P&P indicated, . A plumbing system shall be installed to preclude backflow of a solid, liquid or gas contaminant into the water system at each point of use at the food establishment . providing an air gap .<br><br>During a review of the FDA Food Code Section 5-402.11 Backflow Prevention dated 2022, the FDA Food Code indicated, . 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed .<br><br>During a review of the Food and Drug Administration (FDA), Food Code Section 5-203.14 Backflow Prevention Device dated 2022, the FDA Food Code indicated, . A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT, .backflow prevention is required by LAW, by: (A) Providing an air gap . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555352 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/13/2024 |
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| NAME OF PROVIDER OR SUPPLIER Sunnyside Conv. Hospital | | STREET ADDRESS, CITY, STATE, ZIP CODE 2939 S. Peach Avenue Fresno, CA 93725 | |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430<br><br>Based on observation, interview and record review, the facility failed to establish and maintain an effective infection control and prevention program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable (contagious) diseases and infections for 62 of 62 residents when:<br><br>1.Resident 4's wheelchair was found to have brown dried matter on the seat and staff did not clean and maintain the wheelchair in accordance with facility policies and procedures.<br><br>2.Resident 33's two used urinal bottles (a container used to collect urine) were found on top of his nightstand. Staff did not follow established facility policies for the discarding of urine and the cleaning of urinal bottles.<br><br>3.Dirty water was found pooled in the laundry room where clothing and linens were being washed for the entire facility of 62 residents.<br><br>These failures had the potential to increase the risk of spreading pathogens (microscopic organisms that cause disease) to all residents and staff of the facility.<br><br>4. Resident 214's nephrostomy catheter (a small, flexible tube that is inserted into the kidney through the skin to drain urine) bag was laying on the floor.<br><br>This failure had the potential to cause the bag to become contaminated (the process of making something dirty or unclean) and increase the risk of infection (when germs invade and grow inside the body) for Resident 214.<br><br>Findings:<br><br>1.During an observation on 9/9/24 at 8:01 a.m. in Resident 4's room, brown matter was seen on Resident 4's on the seat of the wheelchair.<br><br>During a concurrent observation and interview on 9/9/24 at 8:32 a.m. with Certified Nursing Assistant (CNA 6), CNA 6 stated, the brown matter on the wheelchair seat was fecal matter (poop). CNA 4 stated, the fecal matter is dried on the wheelchair seat.<br><br>During an interview on 9/12/24 at 3:58 p.m. with the Infection Preventionist (IP), the IP stated, there should no fecal matter dried anywhere on the wheelchair. The IP stated, that [wheelchair] need[ed] to be cleaned and sanitized. The IP stated, if someone else took the wheelchair and sits in it, an infection from feces can result.<br><br>During an interview on 9/13/24 at 2:07 p.m. with the Director of Staff Development (DSD), the DSD stated, any equipment with human excretions (waste from humans such as feces and urine) must be wiped down by Certified Nursing Assistants (CNA). The DSD stated, diseases from feces can be spread to anyone who comes into contact with the surfaces or equipment with feces.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 9/13/24 3:28 p.m. with the Director of Nursing (DON), the DON stated, the expectation is for wheelchairs and other patient care equipment should be cleaned. The DON stated, CNAs are responsible in keeping patient equipment clean. The DON stated, fecal based bacteria such as C-Diff (clostridium difficile-a bacteria that causes infections in the intestines) and E-Coli (Escherichia coli bacteria that causes infections in the intestines) can spread to other residents and staff.<br><br>During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment dated, September 2022, the P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations ., Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident.<br><br>During a review of the facility's P&P titled, Infection Control Guidelines for All Nursing Procedures dated, August 2012, the P&P indicated, Standard Precautions will be used in the care areas of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to .body fluids, secretions, and excretions regardless .<br><br>2.During an observation on 9/9/24 at 8:35 a.m. in Resident 33's room, two urinal bottles were on top Resident 33's bedside table next to drinking cups and personal hygiene supplies. One urinal had brown matter build up inside the bottle.<br><br>During an observation on 9/10/24 at 8:37 a.m. in Resident 33's room, the same two urinals were still on top of the bedside table next to drinking cups and personal hygiene supplies.<br><br>During a concurrent observation and interview on 9/10/24 at 8:40 a.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated, one of the urinals was dirty. CNA 6 stated, she does not know what the brown build up is but stated it is disgusting and the urinal needed to be replaced.<br><br>During an interview on 9/12/24 at 3:23 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, urinals should not be on the bedside table. LVN 3 stated, urinals should be located on the ground under the bed. LVN 3 stated, urinals that is dirty needs to be changed and needs to be changed once a week. LVN 3 stated, a dirty urinal is an infection control issue; any urinal especially a dirty one next to drinking cups can lead to cross contamination to any resident using those cups.<br><br>During an interview on 9/12/24 at 3:30 p.m. with the Director of Staff Development (DSD), the DSD stated, urinals must be changed weekly. The DSD stated, CNAs are typically responsible for changing urinals but is everyone's responsibility to make sure clean equipment is available for the residents.<br><br>During an interview on 9/12/24 at 3:48 p.m. with the Infection Preventionist (IP), the IP was shown a picture taken of Resident 33's urinal. The IP stated, that's a nasty looking urinal .it's dirty all the way in the handle. The IP stated, yes, it's an infection control issue. The IP stated, her best guess is the urinal was older than a week and should have been changed weekly.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 9/13/24 at 3:38 p.m. with the Director of Nursing (DON), the DON was shown a picture taken of Resident 33's urinals. The DON stated, the dirty urinal constituted an infection control issue because it was next to drinking cups and personal hygiene supplies. The DON also stated, urinals should not be on top any resident's bedside table; it should be on the floor under the bed. The DON stated, the expectation is for urinals to be changed once a week.<br><br>During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment dated, September 2022, the P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations ., Durable medical equipment (DME) is cleaned and disinfected before reuse by another resident.<br><br>During a review of the facility's P&P titled, Infection Control Guidelines for All Nursing Procedures dated, August 2012, the P&P indicated, Standard Precautions will be used in the care areas of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to .body fluids, secretions, and excretions regardless .Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., .urinals).<br><br>3.During a concurrent observation and interview on 9/12/24 at 9:40 a.m. with Laundry Staff (LS), in the laundry room, there were 3 washing machines running. Dirty water was pooled on the base of the machines. LS 1 stated, the water was from a leak from one of the washers. LS 1 verified the water was dirty and the machines should not be leaking. LS 1 stated, freshly washed linens from the machines could become re-contaminated by the dirty water if they come into contact with it.<br><br>During an interview on 9/12/24 at 9:58 a.m. with LS 2, in the laundry room, LS 2 stated, the washing machine was leaking and is not sanitary.<br><br>During an interview on 9/12/24 at 10:03 a.m. with the Assistant Direct of Nursing (ADON), the ADON stated, he saw the leak and puddle of water in the laundry room. The ADON stated, it is an infection control issue because anything with water can cause mold or other pathogens to grow and spread to residents and staff.<br><br>During an interview on 9/13/24 at 3:28 p.m. with the Director of Nursing (DON), the DON stated, water leaks in the laundry room can cause mold or legionella (a bacteria that can cause infections in the lungs) to grow. The DON stated, this is an infection control issue and the leak needed to be fixed.<br><br>During a review of the facility's P&P titled, Legionella Water Management Program, dated September 2022, the P&P indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants, including legionella .the identification of situations that can lead to Legionella growth, such as: . water stagnation.<br><br>48424<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4. During a review of Resident 214's Admission Record (AR, documents containing resident demographic information and medical diagnosis), undated, the AR indicated Resident 214 was admitted to the facility on [DATE] with diagnoses which included hydronephrosis (a condition that occurs when urine builds up in the kidney, causing it to swell and stretch), acute kidney failure (a sudden decline in kidney function), and diabetes mellitus (condition where the body has trouble controlling blood sugar levels).<br><br>During an observation on 09/09/24 at 10:05 a.m. next to Resident 214's bed, Resident 214's nephrostomy (a small, flexible tube that is inserted into the kidney through the skin to drain urine) catheter bag was laying on the floor.<br><br>During a concurrent observation and interview on 9/9/24 at 10:21 a.m. with Certified Nursing Assistant (CNA) 3 next to Resident 214's bed, Resident 214 's nephrostomy catheter bag was laying on the floor. CNA 3 stated the nephrostomy catheter bag should not have been on the floor. CNA 3 stated all nephrostomy bags need to be off the floor and laying on the resident's bed. CNA 3 stated having a nephrostomy bag on the floor could have caused Resident 214 to get an infection as a result of germs from the floor entering Resident 214's nephrostomy insertion site (area where the nephrostomy tubing enters the body).<br><br>During an interview on 9/12/24 at 3:26 p.m. with the Infection Preventionist (IP), the IP stated Resident 214 should not have had his nephrostomy bag on the floor. The IP stated Resident 214's nephrostomy bag should have been placed on the bed by Resident 214's leg. The IP stated having a nephrostomy bag on the floor could have caused an infection as a result of germs getting on the surface of the catheter and traveling to the catheter insertion site.<br><br>During an interview on 9/13/24 10:36 a.m. at with the Assistant Director of Nursing (ADON) the ADON stated having Resident 214's catheter on the floor was not dignified and it was an issue of infection prevention. The ADON stated having a nephrostomy catheter bag on the floor could lead to infections and staff should have placed it on the bed if they observed it on the floor.<br><br>During an interview on 9/13/2 4 at 1:38 p.m. with the Director of Staff Development. (DSD) the DSD stated it was unacceptable for the nephrotomy catheter bag to be touching the floor. The DSD stated having a nephrostomy bag on the floor was leaving Resident 214 vulnerable to getting an infection.<br><br>During a review of the facility policy and procedure titled, Infection Control Guidelines for All Procedures, dated 8/12, indicated, .prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on general infection and exposure control issues . Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents including : a. types of healthcare- associated infections; b. Methods of preventing their spread .<br><br>During a review of the Professional reference titled, Catheter-Associated Urinary Tract Infections (CAUTI) Prevention Guideline dated 2/17, (found at https://www.cdc.gov/infection-control/hcp/cauti/background.html) indicated, . pathogens (a living things that causes disease) can enter the urinary tract either by . migration along the outside of the catheter . or by . movement along the internal lumen (the inside of a tube) of the catheter from a contaminated collection bag . |

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|---|---|
| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424<br><br>Based on interview, and record review, the facility failed to maintain a low air loss mattress (LAL- a special mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) cover sheet in intact for one of three sampled residents (Resident 39) when the LAL mattress cover was torn where Resident 39 rested his head.<br><br>This failure had the potential to cause the LAL mattress to not function properly and lead the resident to develop skin breakdown.<br><br>Findings:<br><br>During a review of Resident 39's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 9/13/24, the AR indicated Resident 39 was admitted to the facility on [DATE]. Resident 39 was admitted with the following diagnoses: diabetes mellitus (a condition that happens because of a problem in the way the body uses sugar as a fuel), quadriplegia (a condition which causes partial or total loss of function in all four limbs and the torso), and pressure ulcer of sacral region (a wound that develops when prolonged pressure is applied to the bottom of the back).<br><br>During an observation and interview on 9/9/24 at 9:18 a.m. next to Resident 39's bed, Resident 39's LAL mattress cover sheet had a tear where the resident would rest his head.<br><br>During a concurrent observation and interview on 9/9/24 at 9:27 a.m. with certified nursing assistant (CNA) 3 next to Resident 39's bed, Resident 39's LAL mattress cover sheet had a tear where the resident would rest his head. CNA 3 stated the sheet looked like it had a lot of wear and tear. CNA 3 stated Resident 39 needed the LAL mattress because he has had skin problems in the past. CNA 3 stated if the LAL mattress sheet had a tear it may not function properly.<br><br>During an interview on 9/12/24 at 11:34 A.M. with CNA 2, CNA 2 stated Resident 39 had a LAL mattress because he used to have a wound and the mattress helped prevent it from coming back. CNA 1 stated the LAL mattress cover should not have had a tear on it because it could affect how the LAL mattress functions. CNA 1 stated if the LAL mattress does not function properly Resident 39 may have skin breakdown occur again.<br><br>During an interview on 9/12/24 at 1:38 p.m. with licensed vocational nurse (LVN) 2 LVN 2 stated Resident 39 used a LAL mattress because he had a wound in the past and it helped prevent it from forming again. LVN 2 stated the LAL cover sheet should not have been torn because it could have prevented the LAL mattress from working as intended and caused Resident 39 to retain moisture and develop a pressure ulcer. LVN 2 stated staff should have replaced the LAL cover sheet as soon as they saw it ripped.<br><br>During an interview on 9/12/24 at 3:26 p.m. with the infection preventionist (IP), the IP stated, Resident 39 should not have had his LAL mattress cover ripped. The IP stated a ripped LAL mattress cover affected the ability for staff to properly clean the cover.<br><br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 9/13/24 at 10:36 a.m. with the director of nursing (DON), the DON stated having the cover of the LAL mattress torn could have affected the integrity of the mattress. The DON stated the mattress would not be able to function as intended and having a tear on the cover could make the cover difficult to clean.<br><br>During an interview on 9/13/24 at 1:38 p.m. with the director of staff development (DSD), the DSD stated Resident 39's LAL mattress cover should have been replaced when staff noticed it was torn. The DSD stated it was important to replace the cover because continued use may have damaged it further and caused the LAL mattress to not function properly.<br><br>During a review of the facility's policy and procedure titled, Bed Safety, dated 8/22, , indicated . 1. The resident's sleeping environment is evaluated by the interdisciplinary teen . 8. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications . |

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| F 0911<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.<br><br>41608<br><br>Based on interviews and observations during the survey period from 9/9/24 through 9/13/24, the facility failed to ensure eight of eight sampled bedrooms, accommodated no more than four residents each.<br><br>This failure had the potential for residents to not have reasonable privacy or adequate space.<br><br>Findings:<br><br>Throughout the survey period from 9/9/24 through 9/13/24, eight rooms had more than four residents in each bedroom. The variations were in accordance to residents particular care needs and comfort. Wheelchairs and toilet facilities were accessible to residents. A reasonable amount of privacy was provided, and adequate closet and storage space were available. There was sufficient space for residents to ambulate and staff to provide care to residents. Nursing care of the residents was not impacted.<br><br>During a concurrent observation and interview on 9/10/24 at 10:05 a.m. with Resident 53 in Resident 53's room, Resident 53 was observed sitting in her bed with the back of the bed raised watching television. Resident 53 stated she had no issues sharing her room with seven other residents. Resident 53 stated she felt she had privacy when needed.<br><br>During an interview on 9/12/24 at 4:47 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated, she had no issues providing patient care in the rooms with eight residents. Each Resident had a night stand next to their bed and their own closet space for their clothes and personal belongings. CNA 4 stated she had not received any complaints about personal space from the residents.<br><br>During an interview on 9/13/24 at 1:47 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated, the rooms with eight residents had enough room to provide nursing care. LVN 3 stated the resident privacy curtains do not always close completely when providing care for Residents.<br><br>During an interview on 9/13/24 at 1:52 p.m. with Environmental Services Aid (EVS) 1, EVS 1 stated, the facility provided her with a broom that has a long handle that easily gets under the resident's beds. EVS 1 stated, there was plenty of room to clean the rooms thoroughly.<br><br>Building Room# # of Beds<br><br>2 201 8<br><br>2 202 8<br><br>2 203 8<br><br>2 204 8<br><br>(continued on next page) |

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| F 0911<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | 2 205 8<br><br>2 206 8<br><br>2 207 8<br><br>2 208 8<br><br>Recommend waiver continue in effect.<br><br>________________________________________<br><br>Health Facilities Evaluator Supervisor Signature &<br><br>Date<br><br>Request waiver continue in effect.<br><br>______________________________________<br><br>Administrator Signature & Date |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641<br><br>Based on observation and interview, the facility failed to provide a safe, functional, and comfortable environment for residents, staff and the public when:<br><br>1. Eight of eight resident rooms were observed with non functioning privacy curtains.<br><br>These failures had the potential of violating residents rights to their privacy.<br><br>2. Water leaked from one of three washing machines amd water pooled underneath and around the floor where the machines were located.<br><br>This failure had the potential to place residents and staff in an unsafe and unsanitary environment which had the potential to lead to electrocutions, slips, and other avoidable accidents.<br><br>Findings:<br><br>1. During an observation on 9/12/24 at 9:30 a.m. in room [ROOM NUMBER], door was slightly open, observed a certified nursing assistant providing care to Resident 15, no privacy curtain to the foot of the bed exposing Resident 15 to visitors, staff and other residents walking by the room.<br><br>During an interview on 9/12/24 at 9:43 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated she did not close the privacy curtain when she provided care to Resident 15 because it was not working properly. CNA 9 stated other rooms also has similar problems with the privacy curtains, they were either missing the strings that are used to close them or the strings were tangled or twisted and staff was not able to use the for resdient care. CNA 9 stated she had reported it to maintenance and housekeeping several times and have not taken care of the issues. CNA 9 stated she reports any problems or issues to the maintenance supervisor in person because they did not have any binder to write issues needed to be taken care of by maintenance.<br><br>During a concurrent observation and interview on 9/12/24 at 10:15 a.m. with the Maintenance Supervisor (MS), MS walked arounds and checked all the privacy curtains of the eight resident rooms. MS stated multiple privacy curtains in all eight rooms have non-functioning privacy curtains. MS stated privacy curtains have missing strings to close them and some of the strings are tangled prevented proper use of privacy curtain. MS stated he remembers nursing staff reporting to [NAME] about the privacy curtains and tried to fix some but did not have enough parts to replace the missing strings. MS stated privacy curtains should be working properly to provide resident their privacy because the facility is their home.<br><br>During an interview on 9/12/24 at 2:20 p.m. with the Director of Staff Development (DSD), the DSD stated, . This [facility] is their home, we should make sure to make it a homelike environment for them, everything works and in place . The DSD stated keeping their privacy was one of the resident rights.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555352 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/13/2024 |
| --- | --- | --- | --- |
| NAME OF PROVIDER OR SUPPLIER: Sunnyside Conv. Hospital | | STREET ADDRESS, CITY, STATE, ZIP CODE: 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.

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 9/13/24 at 10 a.m. with both CNA 5 and CNA 10, both CNAs' stated they knew about the issues of privacy curtains with missing and tangled strings. CNA 5 and CNA 10 stated they just needed to make sure they closed the doors when providing care to their residents. CNA 5 and CNA 10 stated they usually report any issues to MS in person.<br><br>During an interview on 9/13/24 at 12:23 p.m. with MS, he stated staff usually reports to him in person for any building issues. MS stated the facility started a new way or reporting or communication for any maintenance issues. MS stated the privacy curtain rails (used to roll the curtain around the bed) in the resident rooms are old and he was having problems finding and ordering parts because there are no available parts. MS stated the owner had to order new parts to fix the privacy curtains.<br><br>During an interview on 9/13/24 at 2:20 p.m. with the Director of Nursing (DON), the DON stated she was made aware of some privacy curtains not working properly. DON stated the curtain rods and rails are old and the MS and owner tried to locate stores who carries the parts but were not able to find any stores.<br><br>During an interview on 9/13/24 at 3:10 p.m. with the Administrator (ADM), the ADM stated she started working four days ago to cover until the facility can find a permanent administrator. The ADM stated the owner and the MS placed an order on 9/6/24 for parts to replace privacy curtain strings. The ADM stated it was important to ensure facility are providing privacy to residents which was one of their resident rights.<br><br>During a review of facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/21, the P&P indicated . 1. Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting .<br><br>During a review of facility's policy and procedure (P&P) titled, Maintenance Services, dated 12/09, the P&P indicated, .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines . providing routinely scheduled maintenance service to all areas . others that may become necessary or appropriate .<br><br>48430<br><br>2. During a concurrent observation and interview on 9/12/24 at 9:46 a.m. with Laundry Staff (LS) 1, LS 1 stated, the pooled dirty water under and around the three washing machines was from a leak inside from one of the washing machines. LS 1 stated, maintenance was aware of the leak for about a year. LS 1 stated, the machines should not be leaking. LS 1 stated, the water on the floor posed a hazard to staff members, they could slip or get electrocuted.<br><br>During an interview on 9/12/24 at 9:58 a.m. with LS 2, LS 2 stated, maintenance was aware of the leak. LS 2 stated, the machine should not have been leaking. LS 2 stated, the pooled water is not sanitary.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a concurrent observation and interview on 9/12/24 at 10:03 a.m. with the Assistant Director of Nursing (ADON), in the laundry room, the ADON stated, there was water pooled in the laundry room. The ADON stated, he doesn't know how long the leak has been going on for. The ADON stated, the situation [flooding] could pose a potential hazard to staff such as electrocution. The ADON stated, mold and other pathogens (disease causing organisms) such as Legionella (a microorganism that can cause lung infections) and mold could grow form stagnant water.<br><br>During an interview on 09/13/24 at 9:05 a.m. with the Administrator (ADM), the ADM stated, the leak was coming from the middle washer. The ADM stated, knew there was a missing plug in the washer's water tank where the soap and water mixed which was the cause of the leak.<br><br>During a concurrent observation and interview on 9/13/24 at 9:21 a.m. with the Maintenance Supervisor (MS) in the laundry room, the MS stated, the leak was coming from the middle washing machine. The MS stated, there was a missing plug in the middle washer that was the cause of the leak.<br><br>During an interview on 9/13/24 at 3:08 p.m. with the MS, the MS stated, the machines should have been repaired. The MS stated, the flooding caused by the leak could potentially cause injury from a slip for those who worked in the area.<br><br>During an interview on 9/13/24 at 3:16 p.m. with the Director of Nursing (DON), the DON stated, the flooding in the laundry room could pose as a safety issue. The DON stated, the staff can slip on the wet floor. The DON stated, this is also a sanitation and infection issue; mold and bacteria can grow in the water. The DON stated, water leaks constitute as an emergency work order and the administrator must be called immediately.<br><br>During a concurrent interview and record review on 9/13/24 at 3:16 p.m. with the DON, the facility's Maintenance Log (ML) dated December 2020 thru September 2024 was reviewed. The ML did not indicate a repair request for a leaking washing machine or flooding in the laundry room. The DON stated, a repair order was not written in the maintenance log and it should have been logged.<br><br>During a review of the facility's policy and procedure (P&P) titled, Maintenance Service dated, December 2009, the P&P indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment .The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .maintaining the building in good repair and free from hazards .the maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner . records shall be maintained in the maintenance director's office .maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned.<br><br>During a review of the facility's P&P titled, Legionella Water Management Program, dated September 2022, the P&P indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants, including legionella .the identification of situations that can lead to Legionella growth, such as: . water stagnation. |