

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/13/2024
NAME OF PROVIDER OR SUPPLIER  Manorcare Health Services (Sunnyvale)		STREET ADDRESS, CITY, STATE, ZIP CODE  1150 Tilton Drive Sunnyvale, CA 94087	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46552</p> <p>Based on interview, and record review, the facility failed to maintain accurate and systematically organized documentation in accordance with accepted professional standards and practices for three of three sampled residents (Resident 1, 2, and 3) when:</p> <ul style="list-style-type: none"> <li>a. Nursing documentation for Resident 1's allegation of abuse was not documented;</li> <li>b. Nursing documentation for Resident 2's allegation of abuse was not documented;</li> <li>c. There were no care plans for Residents 1, 2, and 3 for abuse allegations.</li> </ul> <p>These failures resulted to an inaccurate documentation of the care provided for Residents 1, 2, and 3</p> <p>Findings:</p> <ul style="list-style-type: none"> <li>a. Review of Resident 1's face sheet (a document that gives a resident's information at a quick glance) indicated Resident 1 was admitted to facility on 2/1/2023 with diagnoses including compression fracture (broken bones due to weakened bones) of T 11-12 (lower section of middle back bones), and dorsalgia (back pain)</li> <li>Review of Resident 1's minimum data set (MDS, an assessment tool) assessment dated [DATE] indicated Resident 1's brief interview for mental status (BIMS - an assessment to test a person's cognition level - knowing, learning, and understanding things) score of 14 of 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact).</li> <li>Review of facility reported incident (FRI) to California Department of Public Health (CDPH: state department responsible for public health in California) received on 2/2/2023 at 4:14 p.m., indicated Resident 1 made an allegation about certified nursing assistant (CNA) attempted to provide care while Resident 1 refused and stated no to CNA on 2/2/2023 at 5:00 a.m.</li> <li>Review of Resident 1's nursing general progress notes indicated there was no general progress notes on 2/2/2023 for Resident 1's allegation regarding a CNA who did not stop providing care when Resident 1 refused and said no to CNA.</li> </ul> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Review of Resident 2's face sheet indicated Resident 2 indicated Resident 2 was admitted to facility on 12/11/2019 with diagnoses including multiple sclerosis (a long lasting disease in which body attacks itself by mistake), depression (a mood disorder that causes persistent feeling of sadness and loss of interest), sepsis (a serious condition in which the body responds improperly to an infection), urinary tract infection (an illness in any part of the urinary tract [the system of the organs that makes urine]), and acute respiratory failure (an inability to maintain adequate oxygen [odorless, tasteless, and colorless gas essential to living organisms] for tissues or adequate removal of carbon dioxide [colorless gas, commonly produced by the air when humans breath out] from tissues).</p> <p>Review of Resident 2's MDS assessment dated [DATE] indicated Resident 2's BIMS score of 13 of 15 (intact cognition).</p> <p>Review of FRI to CDPH received on 2/1/2023 at 8:00 a.m., indicated Resident 2 reported felt unsafe, was threatened to be quiet and not given medication by a licensed vocational nurse (LVN) at 4:00 p.m.</p> <p>Review of social service notes for Resident 2, dated 2/3/2023 at 3:34 pm., indicated on 1/31/2023 Resident 2 raised concern about medication not given allegedly, initiated investigation.</p> <p>Review of Resident 2's nursing general progress notes indicated there was no progress notes on 1/31/2023 for Resident 2's allegations of feeling unsafe and received abuse from an LVN.</p> <p>c. Review of FRI to CDPH received on 1/23/2023 at 8:36 a.m., indicated Resident 3's significant family member notified a facility nursing supervisor on duty that a facility employee mishandled Resident 3, three nights ago, possibly on 1/18/2023.</p> <p>Review of care plans for Residents 1, 2, and 3 indicated there was no care plan for allegations of abuse for Residents 1, 2, and 3.</p> <p>During a concurrent clinical record review for Residents 1, 2, and 3, and interview with facility's medical record director (MRD) on 1/8/2024 at 2:34 p.m., MRD confirmed there were no nursing general notes for Residents 1, and 2 for allegations of abuse. MRD also confirmed there were no documented care plans for allegations of abuse for Residents 1, 2, and 3. MRD stated licensed nurse should have documented when allegations of abuse happened. MRD also stated licensed staff should have initiated care plans to address the residents' allegations for Residents 1, 2, and 3.</p> <p>During an interview with registered nurse, unit manager (RN/UM) on 1/8/2024 at 4:02 p.m., RN/UM confirmed there was no documentation and care plans for allegations of abuse for Residents 1, 2, and 3. RN/UM stated licensed staff should have documented residents' allegation of abuse, and initiated care plans to address allegations of abuse for Residents 1, 2, and 3.</p> <p>Review of facility's policy and procedure (P&amp;P) titled, Documentation, Long-term care, revised May 22,2023, the P&amp;P indicated, Documentation associated with documentation includes:</p> <ul style="list-style-type: none"> <li>. assessment findings</li> <li>. resident's care plan</li> </ul> <p>(continued on next page)</p>		

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