

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 03/19/2025
NAME OF PROVIDER OR SUPPLIER Sunnyvale Gardens Post Acute		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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345</p> <p>Based on interview and record review, the facility failed to ensure treatment and care provided were in accordance with professional standards of practice for one (Resident 1) out of two residents, when Resident 1 did not receive a medication ordered by the physician.</p> <p>This failure resulted in multiple missed doses of Resident 1's medication that had the potential to worsen Resident 1's physiological being.</p> <p>Findings:</p> <p>A review of Resident 1's medical record indicated an initial admitted [DATE] and readmitted [DATE] with diagnoses included hepatic encephalopathy (a brain dysfunction that happens when the liver is not working properly), alcoholic cirrhosis of liver with ascites (the liver has become severely scarred due to excessive alcohol consumption, and this scarring has caused fluid to accumulate in the abdominal cavity), liver cell carcinoma (a type of cancer that originates within the liver), and dementia (a decline in mental abilities, including memory, thinking, and reasoning, that interferes with daily life).</p> <p>A review of Resident 1's Minimum Data Set (MDS, an assessment tool), dated 10/4/24, indicated a brief interview for mental status score of 3 [BIMS, a tool used to assess cognition (knowing, learning, and understanding), a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact].</p> <p>A review of Resident 1's Physician Orders indicated: Order Date 7/3/24 21:14 Rifaximin Oral Tablet 550 mg [milligram, unit of measurement] Give 1 tablet by mouth two times a day for hepatic encephalopathy.</p> <p>During an interview on 1/3/25 at 12:33 p.m. with Licensed Vocational Nurse (LVN) A, LVN A stated that the medication Rifaximin was available in the beginning. LVN A also stated that the facility was not able to get it from the pharmacy due to high cost. LVN A stated that Resident 1's relative found a bottle of Rifaximin in Resident 1's drawer and since then, they used that stock.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 1/3/25 at 12:41 p.m. with the Case Manager (CM), the CM verified Resident 1's medical record which indicated, the medication Rifaximin was ordered upon admission on 7/3/24. The CM stated that in August 2024, Resident 1's family member found a bottle of Rifaximin by the bedside. The CM also stated that the medication was brought with the Resident 1 upon admission. The CM stated that residents' belongings must be checked upon admission. The CM verified the Medication Administration Record for July and August 2024 which indicated that Rifaximin was not given from July 26 to August 6, 2024.</p> <p>A review of Resident 1's medical records did not indicate the physician was informed regarding these missed medications.</p> <p>A review of Resident 1's Inventory of Personal Effects dated 7/3/24, no medications were listed.</p> <p>A review of Resident 1's Hospital records titled Death/Discharge Summary dated 12/28/24 indicated, Resident 1 presented to the hospital on 12/15/24 for respiratory failure. Resident 1 had thoracentesis (a medical procedure where a needle is inserted through the chest wall to drain excess fluid from the space between the lungs and the chest wall) done on 12/16/24 and 12/24/24. Resident 1 did not want to pursue another procedure and wanted to focus on comfort. Resident 1 was transitioned to comfort care and passed peacefully with his family at bedside. Resident 1's date of death was 12/28/24.</p> <p>A review of facility's policy and procedure (P&P) entitled, Personal Belongings revised August 2022, the P&P indicated, .10. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary .</p> <p>A review of facility's policy titled Administering Medications with Revision Date April 2019 indicated, POLICY Statement: Medications are administered in a safe and timely manner, and as prescribed. POLICY INTERPRETATION and IMPLEMENTATION . 2. The director of nursing services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescribe orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified . 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record a. the date and time the medication was administered; . 27. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.</p>		