STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555444	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Gardens Post Acute	1150 Tilton Drive Sunnyvale, CA 94087

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to maintain dignity and privacy to five of five residents (Residents 29, 11, 100, 76 and 64) when: 1. Residents 29, 11, 100, and 76's personal information and care guide were posted in their rooms visible to their roommate's visitors; and, 2. Registered nurse L (RN L) did not close the privacy curtain and door during medication administration thru gastric tube (GT - a surgical opening into the stomach for administration of nutrition, and medications). These failures had the potential to negatively affect resident's emotional and psychosocial well-being. Findings: 1a. During an observation on 11/12/2024 at 11:18 a.m., inside Resident 29's room, Resident 29 was in bed. There was a note posted on the wall above Resident 29's head of bed (HOB), which was written in red ink that indicated, Patient is Very Hard of Hearing, and type written in black ink indicated, Patient use pocket talker to communicate (Turn off after use). Another note written in a pad paper was taped at Resident 29's overbed lamp which indicated, PLEASE Wake up (Resident 29's name and room number) For BREAKfast daily !!! During a concurrent observation and interview with registered nurse U (RN U) on 11/14/2024 at 9:12 a.m., inside Resident 29's room, the notes were still posted. RN U confirmed above observation. RN U stated there should be no postings about Resident 29's information and care. During an interview with Resident 29 on 11/14/2024 at 1:03 p.m., Resident 29 stated she did not mind the postings on her wall, but it would be better if staff would cover them. Review of Resident 29's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 29's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. During an observation on 11/12/2024 at 11:47 a.m., inside Resident 11's room, Resident was in bed and there were two notes posted on the wall above Resident 11's HOB. The first note indicated, ATTN [attention]: CNAs [certified nursing assistants]/LN [licensed nurse] PLS. [please] MAKE SURE (Resident 11's name) HAS THICK BLANKET . The second note indicated, ATTN: CNAs SHOWER SCHEDULE MONDAY - AM SHIFT, THURS - AM SHIFT. PLS. ENCOURAGE PATIENT TO SHOWER . During a concurrent observation and interview with RN U on 11/14/2024 at 9:16 a.m., inside Resident 11's room, the notes were still posted. RN U confirmed above observation. RN U stated the notes should not be posted to protect Resident 11's privacy. Review of Resident 11's annual MDS assessment dated [DATE], indicated, Resident 11's BIMS score was 03. 1c. During an observation on 11/12/2024 at 1:01 p.m., inside Resident 100, there was a note posted on Resident 100's closet door. The first note indicated, My Mom's status: She cannot speak English. She cannot feed by herself. Please help her to feed the food when the family is not here._Milk glass: 3-5 spoons, too much will cause her diarrhea. _Sweetie cup: 1/5 cup, too much will cause her diabetes . The second note which was posted at the bottom of the first note indicated, . Please don't raise her feet too high. The blood is hard to come down to her feet . During a concurrent observation and interview with RN U on 11/14/2024 at 9:18 a.m., inside Resident 100's room, the notes were still posted in Resident 100's closet door. RN U confirmed above observation and stated, it was the family who posted the note. RN U further stated it should have been covered with another sheet of paper. Review of Resident 100's quarterly MDS assessment, dated 8/8/2024, indicated, Resident 100 had both short-term and long-term memory problems. 1d. During a concurrent observation and interview with RN U on 11/14/2024 at 9:15 a.m., inside Resident 76's room, there was a note posted at the wall which could be seen once a visitor entered Resident 76's room. The note indicated, Please let her wear ONE layer of diaper each time, NOT two or three . RN U confirmed above postings. RN U stated, it should not be posted or should have been covered. Review of Resident 76's quarterly MDS, dated [DATE], indicated Resident 76 had both short-term and long-term memory problem. During an interview with director of nursing (DON) on 11/18/2024 at 11:10 a.m., DON stated residents' posted care guides should be covered especially when resident was sharing a room with another resident. Review of the facility's policy and procedure titled, Dignity, revised February 2021, indicated, Staff protect confidential clinical information. Examples include the following . b. Signs indicating the resident's clinical status or care needs are not openly posted in the resident's room . Discreet posting of important clinical information for safety reasons is permissible (e.g. taped to the inside of the closet door). 50855 (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 44583 Based on observation, interview, and record review, the facility failed to implement their policy and procedure on self-administration of medication (resident takes medication without staff assistance) when there were no assessments performed for self-administration of medication, and medications were left at bedside for one of six sampled residents (Resident 59). This failure had the potential for unsafe and improper administration of medications. Findings: Review of Resident 59's clinical record titled, Admission Record, indicated, Resident 59 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD- a long lasting lung disease), respiratory disorders, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental illness that causes constant fear). Review of Resident 59's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment, dated 9/27/2024, indicated Resident 59's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview with Resident 59 on 11/12/2024 at 10:05 a.m., inside Resident 59's room, Resident 59 was in bed. There were two bottles of eyedrops placed on top of Resident 59's overbed table. One eyedrop was tetrahydrozoline hydrochloride (a drug that is used as a decongestant for the eyes and nose) and the other one was Visine (a brand name for dry eye relief). Resident 59 stated one of the eyedrops was given by her roommate and she was using both eyedrops. Resident 59 further stated, she had been requesting to self-administer her medications, but her doctor refused her request. During a concurrent observation and interview with licensed vocational nurse J (LVN J) on 11/13/2024 at 10:21 a.m., inside Resident 59's room, the two bottles of eyedrops were still located on top of Resident 59's overbed table. LVN J confirmed above observation. LVN J stated, Resident 59 should not have medications at bedside. LVN J further stated, there should have been an assessment for if Resident 59 was safe to self-administer her medications. LVN J confirmed Resident 59 did not have a physician's order for tetrahydrozoline hydrochloride eyedrops or to have any medications at bedside. Review of Resident 59's clinical record titled, Order Summary Report, dated 11/18/2024, indicated an order of Visine Dry Eye Relief to instill one drop in both eyes every 8 hours as needed for dry eyes. Further review indicated there was no order for tetrahydrozoline hydrochloride eyedrops and no order to have medications at bedside. During an interview with director of nursing (DON) on 11/18/2024 at 11:27 a.m., DON confirmed Resident 59 should not have medications at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure titled, Self-Administration of Medications, revised October 2018, indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so . Self-administered medications are stored in a safe and secure place . Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50855 Based on interview and record review, the facility failed to develop and implement comprehensive care plans that included target symptoms, measurable objectives, and interventions for three out of 26 sampled residents (Resident 6, Resident 106, and Resident 111) as follows: 1. For Resident 6, the facility did not develop care plans for depression (loss of pleasure or interest in activities for long periods of time) and anxiety (apprehensive uneasiness or nervousness usually over an impending or anticipated). 2. For Resident 106, the facility did not develop care plans for depression and Parkinson's disease (a disease that include symptoms of slowness of movements, muscle rigidity, involuntary tremors/shaking and impaired balance, and posture). 3. For Resident 111, the facility did not develop a care plan for the resident's long-standing low sodium levels (measures the amount of sodium in the blood) and hypotension (low blood pressure). These failures had the potential for the residents to not attaining their highest practicable physical, mental, and psychosocial well-being. Findings: 1. Review of Resident 6's clinical record indicated Resident 6 was admitted to the facility with diagnoses includes depression and anxiety. A review of Resident 6's physician's orders indicated the following: -Venlafaxine (an anti-depressant) 150 milligrams (mg, unit of measure) give one tablet by mouth one time a day for depression, dated 10/4/24; and, -Alprazolam (an anti-anxiety medication) 1 mg, give one tablet by mouth at bedtime for anxiety, dated 11/3/24. A review of Resident 6's clinical record indicated there were no comprehensive care plans developed for the resident's depression and anxiety. During a concurrent interview and record review on 11/14/24 at 3:41 p.m., with the Director of Nursing (DON), the DON confirmed there were no care plans developed for Resident 6's depression and anxiety. The DON stated there should have been long-term care plans developed for depression and anxiety. 2. Review of Resident 106's clinical record indicated Resident 106 was admitted to the facility with diagnoses including depression. A review of Resident 106's physician's orders indicated the following: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Nortriptyline (an antidepressant) 25 mg, give 1 capsule by mouth two times a day for depression, dated 8/21/24; and, - Ropinole (medication for Parkinson's disease) 5 mg, 1 tablet one time a day, and 3 tablets in the afternoon for Parkinson's disease, dated 8/22/24. A review of Resident 106's clinical record indicated there were no care plans developed and implemented for the resident's depression and Parkinson's disease. During a concurrent interview and record review on 11/15/24 11:39 a.m., with the Director of Nursing (DON), she stated she could not find the care plans for depression and Parkinson's disease, and confirmed there should have been care plans developed for these medical conditions. 3. Review of Resident 111's clinical records indicated Resident 111 was admitted to the facility with diagnoses including alcoholic cirrhosis (severe scarring) of the liver with ascites (too much fluid build up in abdomen). Review of Resident 111's laboratory results indicated the resident had the following low sodium level readings (normal range 136-145 mEq/L, Milliequivalents per liter): -4/26/23: 128 mEq/L -7/16/24: 122 mEq/L- CL (critical Low) -7/22/24: 128 mEq/L -8/29/24: 131 mEq/L -9/06/24: 128 mEq/L -10/17/24: 129 mEq/L -11/05/24: 130 mEq/L -11/11/24: 131 mEq/L A review of Resident 111's clinical record indicated there were no care plans developed and implemented for the resident's low sodium level. During a concurrent interview and record review on 11/15/24 11:49 a.m., with the DON, the DON stated there were no care plans for low sodium level for Resident 111. She stated there should have long-term care plan for low sodium level. Review of the facility's policy and procedure titled, Care planning -Interdisciplinary team (IDT), revised September 2013, indicated, . facility's Care Planning/IDT [interdisciplinary team] is responsible for the development of an individualized comprehensive care plan for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44583 Based on observation, interview and record review, the facility failed to ensure services provided were in accordance to standards of practice when staff did not use the correct denture cleanser for one out of eight sampled residents(Resident 26). This failure had the potential to affect the integrity of Resident 26's dentures and may not be effective to remove stains and kill bacteria. Findings: During a concurrent observation and interview on 11/12/24 at 10:01 a.m. in Resident 26's room with Certified Nurse Aide (CNA) S, CNA S, with gloved hands, took the dentures from Resident 26's mouth. CNA S proceeded to go to the rest room with a basin and toothbrush. CNA S used liquid hand soap and water to clean Resident 26's dentures. CNA S confirmed she used the liquid hand soap in the rest room to clean the dentures. During an interview on 11/14/24 at 12:59 p.m. with the Infection Preventionist (IP), the IP stated toothpaste must be used to clean residents' dentures and not the liquid hand soap in the rest room. Review of facility's policy and procedure, Dentures, Cleaning and Storing dated 2017, indicated, Clean the dentures by brushing them with a denture cleaner or toothpaste . According to The American College of Prosthodontists [dentists who specialize in restoring and replacing missing or damaged teeth and jaw structure] (ACP) on 4/12/23, the ACP recommends that dentures be cleaned daily by soaking and brushing with an effective, nonabrasive (not rough) denture cleanser to reduce levels of biofilm (slimy layer of bacteria or other tiny living things that stick together on a surface) and potentially harmful bacteria and fungi.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44583 Based on observation, interview, and record review, the facility failed to ensure fall management and safety supervision policy and procedures were implemented for nine out of 10 residents (Residents 18, 76, 106, 26, 30, 90, 108, 116, and 122) when: 1. Staff did not provide 1:1 supervision (one to one continuous observation - terms used for a registered nurse or health care support worker whose role is to provide one to one nursing or observation care to an individual patient for a period of time to help prevent a fall or redirect a patient from engaging in a harmful act) as ordered and/or careplanned for Residents 18, 76 and 106 who were identified as high risk of falling; and 2.Staff did not provide 1:1 supervision, and there were no monitoring logs for Residents 26, 30, 90, 108, 116, and 122 who were identified as at high risk of falling. These failures led to residents at risk for falls to have inadequate falls interventions. Findings: 1a. Review of Resident 18's clinical record titled, Admission Record, indicated Resident 18 was admitted to the facility with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), encounter palliative care (a specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness) and history of falling. Review of Resident 18's clinical record titled, Fall Risk Observation/Assessment, dated 10/1/2024, indicated Resident 18's score was 26 (a score of 0-8 LOW RISK; 9-15 MODERATE RISK; 16-42 HIGH RISK). Review of Resident 18's care plan related to falls indicated an intervention, may provide close supervision up to 1:1 supervision. Further review indicated the intervention was initiated on 9/7/2024. During an observation on 11/12/2024 at 10:57 a.m., inside Resident 18's room, Resident 18 was lying on her bed. There was no 1:1 supervision or a sitter (a trained professionals who cater to clients requiring constant monitoring) inside the room. During a concurrent observation and interview with staffing coordinator (SC) on 11/12/2024 at 11:01 a.m., in front of Resident 18's room, SC confirmed above observation. SC stated the sitter should have notified the certified nursing assistant (CNA) assigned to Resident 18 before she stepped out of the room. SC further stated Resident 18 should always have a sitter. SC confirmed Resident 18's sitter was inside Resident 28's room. Resident 28's bedroom door was closed (Resident 18's room was located next to Resident 28's room). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview with certified nursing assistant V (CNA V) on 11/12/2024 at 11:06 a.m., CNA V stepped out of Resident 28's room. CNA V stated she was assigned as a sitter for Residents 18, 28, 76 and 106. CNA V was observed with a chair placed in between Residents 18 and 28's door. CNA V confirmed it was impossible to supervised Residents 18, 76, and 106 all at the same time because Resident 28 was always in the bathroom and Residents 76 and 106's rooms were located farther. During another observation outside Resident 18's room on 11/12/2024 at 11:55 a.m., CNA V was not seated outside the door, and no one was inside Resident 18's room. During a follow up observation on 11/15/2024 at 8:54 a.m., in front of Resident 18's room, there was no staff/sitter inside Resident 18's room. The sitter was observed inside Resident 28's room. 1b. Review of Resident 76's clinical record titled, Admission Record, indicated Resident 76 was admitted to the facility with diagnoses including Alzheimer's disease, dementia (a progressive state of decline in mental abilities) in other diseases classified elsewhere, unspecified severity, with psychotic disturbance (a collection of symptoms that affect a person's thoughts, perceptions, and ability to distinguish reality from what is not), and history of falling. Review of Resident 76's clinical record titled, Fall Risk Observation/Assessment, dated 9/18/2024, indicated Resident 76's score was 17. Review of Resident 76's clinical record titled, Order Summary Report, indicated, close monitoring up to 1:1 supervision every shift, with order date of 10/4/2024. During a concurrent observation and interview with certified nursing assistant T (CNA T) on 11/13/2024 at 9:16 a.m., outside Resident 18's room, CNA T was observed watching videos on her personal cell phone while seated in between Resident 18's and 28's doors. CNA T confirmed above observation. CNA T stated she was assigned to provide supervision to Residents 18, 28, 76, and 106 and confirmed her use of a personal cell phone was not allowed during working hours. CNA T further stated it was hard for her to check Resident 76 because Resident 76 was located farther down the hallway. During another observation on 11/14/2024 at 9:15 a.m., outside Resident 76's room, Resident 76 was in bed and there was no sitter or staff inside Resident 76's room. The sitter assigned to Resident 76 was seated in between Residents 18 and 28's doors. During a follow up observation on 11/15/2024 at 8:57 a.m., inside Resident 76's room, Resident 76 was asleep, without sitter or staff oversight. 1c. Review of Resident 106's clinical record titled, Admission Record, indicated Resident 106 was admitted to the facility with diagnoses including traumatic hemorrhage of cerebrum (bleeding within the brain tissue itself, caused by head injury or trauma), cognitive communication deficit (difficulty with any aspect of communication that is affected by disruption of cognition), and restless leg syndrome (a nervous system problem that causes an unstoppable urge to move the legs due to uncomfortable sensations like tingling, crawling, or pulling, usually occurring when sitting or lying down, especially at night). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 106's clinical record titled, Fall Risk Observation/Assessment, dated 9/30/2024, indicated Resident 106' score was 24. Review of Resident 106's clinical record titled, Order Summary Report, order dated 9/30/2024, indicated, may provide supervision up to 1:1 supervision, every shift. During a concurrent observation and interview with Resident 106 on 11/12/2024at 1:09 p.m., inside Resident 106's room, Resident 106 was seated on his bed and there was no facility staff or sitter inside or outside the room. Resident 106 confirmed there were times when a staff would sit outside his room. Resident 106 stated staff would not be able to prevent him from falling if they were seated outside his room. During an observation on 11/13/2024 at 9:50 a.m., inside Resident 106's room, Resident 106 was lying on his bed, and there was no staff oversight. During another observation on 11/14/2024 at 9:10 a.m., inside Resident 106's room, Resident 106 was asleep on his bed, leaned more to his right side, and his bed was not in the lowest position. There was no staff oversight. During a follow up observation on 11/15/2024 at 3:50 p.m., outside Resident 106's room, Resident 106 was observed transferring self from bed to his wheelchair. There was no staff available to assist Resident 106. Resident 106's sitter was observed seated in front of Resident 18 and 28's rooms. During an interview with certified nursing assistant W (CNA W) on 11/15/2024 at 3:51 p.m., CNA W confirmed he was the sitter assigned for Residents 18, 28, 76 and 106. CNA stated his assignment was not effective because, accidents could happen in just 1 second. During an interview with director of nursing (DON) on 11/18/2024 at 11:16 a.m., DON confirmed plan of care such as to provide 1:1 supervision should be implemented especially when there was a physician's order, and it was indicated in resident's care plan. Review of the facility's undated policy and procedure titled, Falls and Fall Risk, Managing, indicated, The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with history of falls. During a review of the facility's undated policy and procedure titled, Safety and Supervision of Residents, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Resident supervision is a core component of the systems approach to safety. 49345 2. During a concurrent observation and interview on 11/15/24 at 9:29 a.m. with CNA D, CNA D stated she was assigned as the sitter for six residents (Residents 26, 30, 90, 108, 116, and 122). CNA D also stated she sat on a chair along the hallway. CNA D also stated she was not sure if she can prevent a fall and being a sitter for six residents was hard. CNA D stated they use to have just 1:1 (one staff per resident) sitter. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Gardens Post Acute	1150 Tilton Drive Sunnyvale, CA 94087

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/15/24 at 3:16 p.m. with the Director of Nursing (DON) and the Administrator (ADM), the ADM stated, We cannot stop every single fall. 1:1 sitter is rare. The DON stated there was a monitoring log for the sitters to use for the residents. During a concurrent interview and record review on 11/15/24 at 3:25 p.m. with CNA D, CNA D verified she had no monitoring log while being the sitter for six residents. CNA D also stated there was no form to record what the resident was doing. CNA D presented a paper with handwritten note of room numbers of residents she was watching. During a concurrent observation and interview on 11/18/24 at 10:38 a.m. with Laundry Aide E (LA E), LA E stated she was the sitter for four residents. LA E was able to state the resident rooms but was not able to provide the Residents' names. LA E stated, I am watching them not to fall. LA E stated she would call the CNA or the nurse if help was needed. LA E verified she had no monitoring log for the residents. During an observation on 11/18/24 at 11:06 a.m., LA E entered Resident 122 and Resident 90's room and assisted both residents with their call light buttons. During an interview on 11/18/24 at 1:26 p.m. with the DON, the DON stated that laundry aides can be sitters, but they are not supposed to do any direct patient care. A review of facility's policies and procedures, Safety and Supervision of Residents, dated 2001, indicated, . Individualized, Resident-Centered Approach to Safety . 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff .e. Documenting interventions .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 44583 Based on observation, interview and record review, the facility failed to follow their policy and procedures for enteral feeding (a method of delivering nutrients and fluids directly to the gastrointestinal [GI] tract) care for two of two sampled residents (Residents 110 and 64) when: 1. Licensed vocational nurse G (LVN G) did not check the placement (by injecting air and listening to the stomach with a stethoscope) of a gastrostomy tube (G-tube, a tube that goes directly into the stomach to deliver feeding formula and medications), and did not check for any residual (the amount of fluid remaining in the stomach after enteral feeding, which is measured by withdrawing the fluid with a syringe and checking the amount) prior to flushing the G-tube with water; and, 2. Registered nurse L (RN L) did not check G-tube placement before G-tube medication administration. These failures had the potential for enteral feeding complications (such as aspiration of medications, enteral formula, water) that could cause harm to Residents 110 and 64. Findings: 1. Review of Resident 110's clinical record titled, Admission Record, indicated Resident 110 was admitted to the facility with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following unspecified cerebrovascular disease (CVA, commonly referred to as stroke) affecting right dominant side, dysphagia (difficulty in swallowing) following cerebral infarction (also known as stroke), and gastrostomy status. Review of Resident 110's order listing report indicated, Enteral Feed Order every shift. Check and record residuals every shift. If residuals are greater than 100ml hold feeding and call physician .Enteral Feed Order every shift. Check tube placement and patent 1) visual 2)auscultation 3) gastric content aspiration. Both orders had a revision date of 4/17/2024. During an observation on 11/13/2024 at 9:40 a.m., inside Resident 110's room, Resident 110 was in bed. LVN G flushed the G-tube with water without checking the G-tube placement and without checking for a residual. LVN G checked the G-tube residual after she flushed it with water. During a follow up interview with LVN G on 11/13/2024 at 10:00 a.m., LVN G confirmed above observation. LVN G stated she should have checked the GT placement and checked for residual prior to flushing it with water. During an interview with director of nursing (DON) on 11/18/2024 at 2:18 p.m., DON stated nurses should check the GT placement prior to flushing it with water or medication administration. DON further stated, nurses should also checked for residual prior to flushing, tube feeding or medication administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's undated policy and procedure, Enteral Feedings - Safety Precautions, indicated, Preventing aspiration [when a fluid or solid accidentally enters your windpipe and lungs]: 1. Check enteral tube placement every 4 hours and prior to feeding or administration of medication. 2. Check gastric residual volume as ordered . 2. During a concurrent observation and interview on 11/12/24 at 4:21 p.m., with Registered Nurse L (RN), RN L was observed administering five medications to Resident 64 via G-tube, but she did not check the G-tube placement before administering the medications. During an interview on 11/12/24 at 4:40 p.m., with RN L, she stated she forgot to check Resident 64's G-tube placement before administering medications. RN L stated she typically would not check the G-tube placement first before administering the medication. During an interview on 11/13/24 at 09:42 a.m., with Director of Nursing (DON), the DON stated nurses are supposed to check G-tube placement with stethoscope (a medical device use for listening to internal sounds of human body) by auscultation (the action of listening to sounds from the heart, lungs, or other organs) before administering medication. During a review of facility's policy and procedure, Administering Medications through an Enteral Tube, dated 2001, the P&P indicated, Equipment .12. Stethoscope . Steps in the procedure . 6. Verify placement of feeding tube: a. if you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician .

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F 0700 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview, and record review, the facility failed to follow their policy regarding use of side rails (also called bedrails, metal or plastic bars attached to the bed ranging in size from full to one-half, one quarter, or one-eighth lengths) for one out of 26 sampled residents (Resident 22), when Resident 22 did not have a documented physician's order for the use of side rails, there was no documentation that indicated the facility attempted alternatives prior to installing the side rail, and there was no documentation that indicated the facility assessed for risk of entrapment (getting caught, trapped, or entangled in the space in or around the side rail). These failures had the potential to compromise the resident's safety. Findings: During an observation on 11/12/24 at 11:38 a.m., the bed of Resident 22 was inspected. Resident 22's bed had one upper 1/4 side rail in the upright position on the left side of the bed. No side rail was observed on the right side of the bed. During an observation on 11/13/24 at 10:33 a.m., inside Resident 22's room, Resident 22 was seated on a wheelchair and her bed was observed with an upper left side rail in the upright position. No side rail was observed on the right side of the bed. Review of Resident 22's admission record indicated she was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (a disease affecting the brain and spinal cord that disrupts the communication of the brain and the rest of the body), and fracture (a partial or complete break in the bone) of the shaft (middle part of a long bone) of the right ulna (the long, thin bone in the lower part of the arm). Review of Resident 22's medical record indicated she had a physician's order, dated 11/13/24, May have bilateral 1/4 side rails as enabler for bed mobility and positioning. There was no documentation in the medical record that indicated the facility attempted alternatives prior to installing Resident 22's side rail and no care plan for side rail use was developed prior to Resident 22's use of side rail. Review of Resident 22's bed rail evaluation report, dated 10/29/24, indicated Resident 22 did not require the use of bed rails. During an interview conducted on 11/18/24 at 2:20 p.m. with licensed vocational nurse B (LVN B), she stated a bed rail evaluation is done for residents before the bed rails are applied. LVN B stated all orthopedic residents are assessed for an overhead trapeze and other alternatives before bed rails are installed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review with the director of nursing (DON) on 11/18/24 at 2:24 p.m. , the DON reviewed Resident 22's bed rail evaluation report dated 10/29/24. The DON confirmed Resident 22's bed rail evaluation report indicated Resident 22 did not require the use of bed rails. The DON further confirmed there was no documentation indicating alternatives were offered, no physician order and consent were obtained, and no care plan for side rail use was developed prior to Resident 22's use of a side rail. The DON stated There was a physician's order for the side rail and a nursing care plan for the side rail, but I cannot find it in the records. During a concurrent interview and record review on 11/18/24 at 2:24 p.m. with DON, she confirmed Resident 22 had a side rail. The DON reviewed the medical record of Resident 22 and confirmed there was a physician order dated 11/13/24 for bed rails, but no documentation that indicated the facility attempted alternatives prior to installing the bed rail and no development of a nursing care plan for bed rail use. During a review of the facility's policy and procedure titled, Bed Safety and Bed Rails, dated August 2022 indicated, Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one quarter, or one-eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed . For the purpose of this policy bed rails include: a. side rails; b. safety rails; and c. grab/assist bars. Prior to the installation or use of a side rail or bed rail, alternatives to the use of side rails or bed rails are attempted. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: b. the resident's risk associated with the use of bed rails; c. input from the resident and/or representative and d. consultation with the attending physician. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44583 Based on observation, interview, and record review, the facility failed to ensure staff had the necessary competency to respond to resident's needs when two (Resident 90 and Resident 122) out of four residents were assisted by the laundry aide. This failure had the potential for the facility to not meet residents' safety needs. Findings: During an interview on 11/15/24 at 3:16 p.m. with the Director of Nursing (DON), the DON stated there was a monitoring log for the sitters to use for the residents. During an interview on 11/18/24 at 10:38 a.m. with Laundry Aide (LA) E, LA E stated she was assigned to be the sitter for four residents, but was not able to state the names of the residents she was assigned to watch. LA E also stated, I'm just watching them not to fall down. I call the CNA [Certified Nurse Aide] or the nurse if I need help right away. LA E confirmed she did not have a monitoring log while watching residents. During a concurrent observation and interview on 11/18/24 at 11:06 a.m., Laundry Aide E (LA E) entered Resident 122's room, took Resident 122's call light button from the floor and clipped it on Resident 122's bed. LA E then went to Resident 122's roommate, Resident 90, LA E held Resident 90's call light button and asked if Resident 90 needs it. LA E exited the room. LA E confirmed she did not do hand hygiene upon entering the residents' room, after touching Resident 122's call light button and moving to Resident 90 and touching his call light button, and upon exiting the room. LA E also confirmed she did not sanitize Resident 122's call light button after picking it up from the floor and then clipping it on Resident 122's bed. LA E stated she should have used hand sanitizer upon entering and exiting the residents' room. During an interview on 11/18/24 at 1:26 p.m. with the Director of Nursing (DON), the DON stated that laundry aides can be sitters and were trained to be sitters but must not do any direct patient care. The DON also stated that they must also know about infection control such as hand hygiene. A review of Resident 90's comprehensive care plan initiated on 9/29/24 indicated, May provide close supervision up to 1:1 supervision as needed/indicated. A review of Resident 122's comprehensive care plan initiated on 10/10/24 indicated, Keep within supervised view as much as possible. A review of facility's Job Description for Laundry Aide revised 2/08, indicated, Job Summary Perform a variety of general laundry duties to provide quality, clean laundry service .Essential Job Functions . Safety and Sanitation .Observes safety needs of patients as indicated in care plan . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's document entitled Nurse Assistant Training Program Counseling Form for LA E dated 6/9/23, indicated, Description of Incident: Not Able to Cope with the theory. Quizzes are low. Plan of Action: To go back to laundry or be a sitter . A review of facility's policy and procedure, Safety and Supervision of Residents, dated 2001, indicated, Individualized, Resident- Centered Approach to Safety . 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; . e. Documenting interventions . 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to provide appropriate social services (SS) support for one of three residents (Resident 59) when there was a lack of SS support for Resident 59, who had a history of domestic violence (also called intimate partner violence, a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner). This failure resulted in a lack of timely psychosocial support for Resident 59. Findings: Review of Resident 59's clinical record titled, Admission Record, indicated, Resident 59 was admitted to the facility initially on 3/22/2024 with diagnoses including chronic obstructive pulmonary disease (COPD- a long lasting lung disease), respiratory disorders (a type of disease that affects the lungs and other parts of the respiratory system), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental illness that causes constant fear). Review of Resident 59's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 59's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview with Resident 59 on 11/12/2024 at 10:05 a.m., inside Resident 59's room, she was seated on her bed, with oxygen in placed thru nasal cannula (a tubing used to deliver oxygen from the machine through the nostrils). Resident 59 stated she had been on antidepressant (type of medication used to treat depression) and anti-anxiety (a type of medication used to prevent or relieve anxiety) medications. Resident 59 further stated, she had been requesting to be seen by her own psychiatrist, but nobody followed up with her. Resident 59 confirmed SS never visited her regarding her request. Review of Resident 59's clinical records titled, Order Summary Report, indicated an order dated 3/25/2024 for Buspirone Hydrochloride (anti-anxiety - a type of medication used to prevent or relieve anxiety) 15 milligrams (mg - unit of measurement) two times a day and 30 mg one time a day for anxiety manifested by (m/b) verbalization of being anxious due to husband will be out of jail soon. It was indicated Resident 59 had history of physical abuse from her husband. Further review indicated an order dated 3/25/2024 for Mirtazapine (antidepressant - type of medication used to treat depression) 15 mg at bedtime for poor appetite and the medication dosage was changed to 7.5 mg on 11/10/2024. It had order dated 3/22/2024 for Setraline hydrochloride 100 mg two times a day for depression m/b verbalization of sadness. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 59's Social History assessment dated [DATE], it indicated, Resident 59 had experienced physical assault, assault with a weapon, sudden, and unexpected death of someone close to her. Further review indicated, Domestic violence, was the stressful event or experienced she had. Resident 59 scored 24 (a score of 20 -27, severe depression) in her mood interview. It indicated a note that Resident would be referred to psychiatric services. Review of Resident 59's care plan titled, At risk for decreased psychosocial well-being and emotional distress ., date initiated 3/30/2024, indicated, Resident mood sx (symptom) presence are related to current health problems, abusive spouse and son on drugs Interventions .Encourage expression of feelings/concerns .Social Services to visit and evaluate as needed . During a concurrent interview with social services director (SSD) and record review on 11/18/2024 at 10:27 a.m., SSD reviewed SS progress notes and the latest psychiatric note dated 8/27/2024. SSD confirmed Resident 59 was under Adult Protective Services (APS) before due to domestic violence, but APS closed the case when Resident 59 was admitted to the facility. SSD confirmed she did not find any documentation of SS visits to Resident 59 to address her mood and there was no other psychiatric follow up done in September, October, and November 2024. SSD further confirmed, the progress notes she found were just related to Resident 59's room changed. SSD stated Resident 59 should have a weekly SS visit and it should have been documented under progress notes. During concurrent interview with director of nursing (DON) and record review on 11/18/2024 at 11:54 a.m., DON reviewed Resident 59's clinical records related to SS visits. DON confirmed there were no documented SS visits to address Resident 59's mood. DON stated SS should have documented their visits with Resident 59. During a review of the facility's document titled, Job Description: Social Services Director, dated 4/29/2024, indicated, Essential Duties .Provide medically related social services so that the highest practicable physical, mental and psychosocial well-being of each resident is attained or maintained. Evaluate social and family information, psychological and emotional needs to assist in assessing social services needs as well as develop care plans for social services issues . Document regarding resident social service status . Counselling residents and family members .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 50855 Based on interview and record review, the facility failed to ensure accurate accountability of controlled drugs (medications that can be easily abused and are under strict government control) and document medication administration as in accordance with the facility policy and procedures (P&P) for one out of six sampled residents (Resident 2). The failure had the potential for medication errors and controlled drug abuse or diversion (when healthcare providers obtain or use prescription medicines illegally). Findings: Review of Resident 2's clinical record indicated Resident 2 was admitted to the facility with diagnosis includes type 2 Diabetes Mellitus (DM- a condition which affects the way the body processes blood sugar) with Diabetic Neuropathy (a nerve damage that can occur in people with diabetes). Review of Resident 2's physician's order indicated an order, dated 5/12/2023, for oxycodone (a potent controlled medication for pain)5 mg (milligram, unit of measurement), 1 tablet by mouth every 4 hours as needed for moderate pain; and 10 mg, 1 tablet every 6 hours as needed for severe pain. During a concurrent interview and record review on 11/14/24 at 09:04 a.m., with Director of Nursing (DON), a review of Resident 2's Controlled Substance Accountability Sheet (CSAS) for oxycodone 10 mg and the June, July, September, October, and November Medication Administration Records (MARs) indicated, on 8 occasions, the nursing staff signed out one tablet on CSAS but did not document their administration on the MAR, as follows: -6/23/24 at 1020 -7/4/24 at 1000 -7/6/24 at 0612 -7/18/24 at 0600 -9/2/24 at 1015 -9/19/24 at1932 -10/29/24 at 1030 -11/4/24 at 600 Similarly, a review of Resident 2's CSAS for oxycodone 5 mg and the September, October, and November MARs indicated the nursing staff signed out of the CSAS but did not document the administration on the MAR to show they were administered to the resident on the following dates and times: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/12/24 at 0600 -1/6/24 at no time entered -10/15/24 at 0610 -11/5/24 at 0600 -11/10/24 at 0645 During an interview and record review above, the DON confirmed the findings and acknowledged a 13 oxycodone tablets for Resident 2 were not accounted for. The DON stated nurses should sign the CSAS and document on the MAR after they administered the medication. Review of facility's policy and procedure (P&P) titled, Controlled Substances, revised April 2019, indicated, 10. upon administration a. The nurse administering the medication is responsible for . (3) Time of administration . (6) signature of nurse administering medication . Review of facility's P&P, Administering Medications, dated 2001, it indicated, .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; b. the dosage; .e. any complaints or symptoms for which drug administered was administered; f. any result achieved and when those results were observed; and g. the signature and title of the person administering the drug .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 44583 Based on observation, interview, and record review, the facility failed to ensure two of 26 sampled residents (Residents 6 and 111) were free from unnecessary medications when Resident 6 received Lasix (used to treat edema [fluid retention; excess fluid held in body tissues]) and Resident 111 had two orders for oxycodone (a potent controlled medication for pain) 5 milligram (mg, unit of measure). This deficient practice resulted in unmonitored medical condition; and, duplicate orders that had the potential for excessive dose/adverse effects for the resident. Findings: 1. Review of Resident 6's clinical record indicated Resident 6 was admitted to the facility with diagnosis including heart failure (a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). A review of Resident 6's physician's orders indicated an order for Lasix 20 mg, 1 tablet by mouth one time a day for edema HOLD if (systolic blood pressure) SBP < (is less than) 100, dated 11/10/24. A review of Resident 6's medication administration record (MAR) indicated the nursing staff did not monitor for the edema. During a concurrent interview and record review on 11/14/24 03:41 p.m., with the Director of Nursing (DON), the DON reviewed Resident 6's physician's orders and confirmed there was no monitoring for edema. The DON stated Resident 6 should have monitoring for edema in the MAR. 2.During a review of Resident 111's clinical record indicated Resident 111 was admitted to the facility with diagnoses including alcoholic cirrhosis (severe scarring) of the liver with ascites (too much fluid builds up in abdomen). During a review of Resident 111's physician's orders indicated he had two identical orders of oxycodone 5 mg with two different order dates, as follows: - Oxycodone 5 mg Give 1 tablet by mouth every 6 hours as needed for Moderate to severe pain, dated 8/15/24. - Oxycodone 5 mg Give 1 tablet by mouth every 6 hours as needed for moderate to severe pain, dated 9/3/24. A review of Resident 111's November MAR indicated there were two entries for oxycodone orders on the MAR. During a concurrent interview and record review on 11/15/24 11:54 a.m., with the DON, she reviewed Resident 111 physician's order and confirmed there were duplicate orders of oxycodone 5 mg on the physician's orders and on the MAR. The DON stated oxycodone tablet 5 mg 1 tablet dated, 08/15/24 should have been discontinued and Resident 111 should have only one order of oxycodone. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedures titled, Medication Therapy, revised April 2007, indicated, Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks . Medication use shall be consistent with an individual's condition . All medication orders will be supported by appropriate care and practices . All decisions related to medications shall include appropriate elements of the care process, such as . The frequency of administration and duration of use are appropriate .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interviews, and record review, the facility failed to ensure three out of 26 sampled residents (Residents 59, 6, and 63) were free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications when: 1. Resident 59 received an anti-anxiety (a type of medication used to prevent or relieve anxiety) and two different antidepressants (type of medication used to treat depression) without documentation wherein non-pharmacological interventions were attempted prior to psychotropic medication used; 2. Resident 63 received Abilify (is an antipsychotic [drugs treat psychosis] medication that helps treat several kinds of mental health conditions) without target behavior monitoring, and there was no documentation of non-pharmacological interventions implemented; and, 3. Resident 6 received Trazodone (anti-depressant medication) without monitoring for hours of sleep. These failures had the potential for increased risks associated with the use of psychotropic medications that could negatively affect the residents physical mental and psychosocial well-being. Findings: 1. Review of Resident 59's clinical record titled, Admission Record, indicated, Resident 59 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD- a long lasting lung disease), respiratory disorders, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental illness that causes constant fear). Review of Resident 59's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 59's brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). Review Resident 59's clinical records titled, Order Summary Report, indicated an order dated 3/25/2024 for Buspirone Hydrochloride (an anti-anxiety medication) 15 milligrams (mg - unit of measurement) two times a day and 30 mg one time a day for anxiety manifested by (m/b) verbalization of being anxious due to husband will be out of jail soon. It was indicated Resident 59 had history of physical abuse from her husband. Further review indicated an order dated 3/25/2024 for Mirtazapine (an antidepressant) 15 mg at bedtime for poor appetite and the medication dosage was changed to 7.5 mg on 11/10/2024. There was an order dated 3/22/2024 for Setraline hydrochloride (antidepressant) 100 mg two times a day for depression m/b verbalization of sadness. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 59's clinical records such as nursing progress notes and medication administration records did not indicate non-pharmacological interventions were initiated in March 2024 prior to the used of anti-anxiety and antidepressant medications. During a concurrent interview with social services director (SSD) and record review on 11/18/2024 at 10:27 a.m., SSD reviewed Resident 59's order summary report and the November medication administration records. SSD confirmed there were no documented non-pharmacological interventions attempted prior to psychotropic medication administration when ordered in March 2024. SSD stated she did not know the non-pharmacological interventions to be attempted prior to psychotropic medication administration. During a concurrent interview with director of nursing (DON) and record review on 11/18/2024 at 11:54 a.m., DON reviewed Resident 59's clinical records. DON confirmed there were no non-pharmacological interventions attempted prior to use of psychotropic medications in March. DON confirmed the non-pharmacological interventions were only initiated on 11/15/2024 prior to the use of antidepressants while the recertification survey was in progress. DON stated the pharmacy consultant did the monthly audit, this might be overlooked that's why it was missed. 50855 2. During a review of Resident 63's clinical record indicated Resident 63 was admitted to the facility with diagnosis including psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and Alzheimer's disease (a progressive disease that destroys memory and mental functions). During a review of Resident 63's physician's orders indicated an order for Abilify 5 milligram (mg, unit of measure), give 1 tablet by mouth at bedtime for (manifested by) delusional [a belief in something that is not true] thoughts such as thinking people are stealing from her, dated 10/12/2024. A review of Resident 63's clinical indicated there was no monitoring for the target behavior of delutional thoughts such as thinking of people are stealing from her and there were no documentation of non-pharmacological interventions implemented for Resident 63. During an interview on 11/14/24 at 10:05 a.m., with Certified Nursing Assistant N (CNA N), CNA N stated Resident 63 never refused her care and did not have any behaviors. During an observation on 11/14/24 at 11:53 a.m., Resident 63 was observed walking inside her room, calm, smiling and speaking on her native language. During a concurrent interview and record review on 11/14/24 at 11:58 a.m., with License Vocational Nurse M (LVN M), LVN M reviewed Resident 63's Physician orders and confirmed there was no behavior monitoring for Psychosis M/B delusional thoughts such as thinking people are stealing from her, related to the use of Abilify. LVN M also stated she did not see documentation for non-pharmacological interventions. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/14/24 at 12:20 p.m., with the Director of Nursing (DON), the DON reviewed Resident 63's clinical record and confirmed there was no behavioral monitoring for Ability, and there was no documentation for non-pharmacological interventions. The DON stated residents' target behaviors should monitored every shift to see if medication is effective. 3. During a review of Resident 6's clinical record indicated Resident 6 was admitted to the facility with diagnoses including depression (loss of pleasure or interest in activities for long periods of time) and anxiety (apprehensive uneasiness or nervousness usually over an impending or anticipated ill). During a review of Resident 6's physician's order indicated an order for trazodone 100 mg, give 1 tablet by mouth at bedtime for Depression m/b insomnia (inability to sleep) Monitor for sleep hours, dated 10/2/24. A review of Resident 6's medication administration record (MAR) indicated the nursing staff did not monitor for the number of hours the resident slept each shift or day since 10/2/24. During a concurrent interview and record review on 11/14/24 at 03:41 p.m., with the DON, the DON reviewed Resident 6's physician's order and the MAR and confirmed there was no number of hours of sleep on Resident 6's MAR. The DON stated it should have monitored the hours of sleep. During a review of the facility's P&P titled Psychotropic Medication, dated 12/2019, indicated: The facility supports the goal for using psychotropic medications appropriately working with the interdisciplinary team in conjunction with the Physician to ensure, evaluation and monitoring. During a review of facility's P&P titled, Behavioral Assessment, Intervention and Monitoring dated 2001, the P&P indicated, . Current guidelines recommended the use of non-pharmacological interventions for Behavioral or Psychological Symptoms of Dementia (BPSD).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50855 Based on observation, interview, and record review, the facility had a medication error rate of 10% when three medication errors occurred out of 30 opportunities during the medication administration for three out of seven residents (Resident 8, Resident 64, and Resident 51). The failures resulted in the nursing staff not following physician's orders and the facility's policy and procedures (P&P), which had the potential for the residents not receiving full therapeutic effects, or complications from medications. Findings: 1. During the medication administration observation on 11/12/24 at 9:27 a.m., Licensed Vocational Nurse F (LVN F) was observed preparing and administering seven medications for Resident 8. Included in the medications was an oral inhaler called Dulera (a combined medication that includes a corticosteroid, used to control, and prevent the symptoms of asthma). LVN F handed the inhaler to Resident 8 and did not provide instructions for how to use the inhaler. The resident did not breathe in deeply before inhaling the medication, did not close her mouth and hold her breath after each puff, and gave herself two puffs simultaneously without allowing some time in between the puffs. There was about a four or five-second time lapse between the two puffs. During this administration, LVN F also did not offer water for the resident to rinse her mouth afterwards. During a concurrent interview and record review shortly after the observation, on 11/12/24 at 9:44 a.m., LVN F was asked if he instructed Resident 8 to breathe in deeply, hold her breath after each puff, and allowing time between puffs, he said he forgot to instruct Resident 8. He also stated he should have instructed her to wait about two minutes in between the two puffs. LVN F was asked to review the physician's order for Dulera; then after the review, he stated he forgot to have the resident rinse her mouth with water which he stated for the purpose of preventing oral thrush [yeast infection]. A review of Resident 8's clinical record indicated a physician's order, dated 3/23/2024, for Dulera Inhalation Aerosol 100-5 micrograms/actuation (unit of measurement), inhale 2 puffs orally two times a day for asthma rinse mouth after use. During an interview on 11/13/24 9:42 a.m. with the Director of Nursing (DON), the DON stated, during the administration of an inhaler, The nurse instructs them [residents] to inhale and hold the breath and for 2 puffs inhaler, need to wait 3 to 5 minutes in between. During a review of the facility's P&P titled Administering Medications through a Metered Dose Inhaler, dated 2017, indicated, . 14. Administer medication: g. instruct resident to inhale deeply and hold for several seconds .15. Repeat inhalation, if ordered. Allow at least (1) minute between inhalations of the same medication . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During the medication administration observation on 11/12/24 at 4:15 p.m., Registered Nurse L (RN L) was observed preparing 5 medications, 1 inhaler and 4 solid medications for Resident 64. The resident was receiving medications via the gastrostomy tube (or G-tube, tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). RN L crushed each solid medication separately and diluted each with about 10 milliliters (mL, unit of measurement) of water. On 11/12/24 at 4:21 p.m., RN L was observed withdrawing each of the medication from medicine cup with 60-ML syringe and injected into Resident 64's G-tube, one by one, without flushing of water in between the 4 medications. She flushed the G-tube about 60 ML of water after the last medication. During an interview shortly after the observation, on 11/12/24 at 4:40 p.m., RN L confirmed she did not flush Resident 64's G-tube with water between the medications. She said she was supposed to flush water in between medication, but she forgot. During an interview on 11/13/24 at 9:42 a.m., with the DON, she stated, for G-tube medication administration, the nurse should flush 30 ML of water before and after, and 5 ML of water in between medication. A review of the facility's P&P titled Administering Medications through an Enteral Tube, dated 2001, indicated, .13. If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications . 3. During the medication administration observation on 11/13/24 at 9:25 a.m., Licensed Vocational Nurse J (LVN J) was observed administering 6 medications for Resident 51. Included in the medications was an eyedrop called cyclosporine Ophthalmic (used to increase tear production in people with dry eye disease) 0. 05%. LVN J was observed instilling 1 drop directly to iris (the colored part of the eye) of Resident 51's eyes without pulling the lower eyelid down and not instructing to look up. LVN J then immediately wiped the resident's eyes with a tissue as soon as the drop was instilled. During an interview shortly after the observation, on 11/13/24 at 9:31 a.m. with LVN J, she confirmed she instilled the drops directly into the resident's iris and did not pull the resident's lower eyelid to make a pocket to instill the medication in during eyedrop administration. During an interview on 11/13/24 at 9:42 a.m. with the DON, she stated during eyedrop administration, they [nurses] need to instill the medication inside the pocket by pulling down the lower eyelid and press on the lacrimal duct (tear duct) after the instillation. During a review of the facility's P&P titled Instillation of Eye Drops, dated 2001, indicated Steps in the Procedure, Gently pull the lower eyelid down. Instruct the resident to look up. 8.Drop the medication into the mid lower eyelid (fornix). (Note: Do not touch eye or eyelid with the dropper.) Recap the medication bottle. 9. Instruct the resident to slowly close his/her eyelid to allow for even distribution of the drops. Instruct the resident not to blink or squeeze the eyelids shut, which forces the medicine out of the eye .

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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. 50855 Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications when opened multi-dose vials/inhalers had no open date; unopened latanoprost (used to treat glaucoma [group of eye diseases that can cause vision loss and blindness]) bottles were not stored in the refrigerator as per manufacturer's labeling; and, expired medications were not removed from active stock. These failures had the potential for residents to receive medications with reduced efficacy. Findings: 1. On 11/12/24 at 11:39 a.m., an inspection of the medication refrigerator in Station 2 Medication Room with the Director of Nursing (DON) identified one opened multi dose vial of insulin and two opened bottles of lorazepam oral solution was found without open date label. A review of the manufacturer's label on the insulin vial indicated it must be discarded 28 days after being opened. The manufacturer's label for lorazepam oral solution indicated to discard opened bottle after 90 days. The DON confirmed this finding and stated insulin vials and lorazepam oral solutions should have an open date to ensure they are not being used past their discard dates. 2. During an inspection of Medication Cart 2B on 11/12/24 at 2:03 p.m., with Licensed Vocational Nurse F (LVN F), LVN F confirmed the following findings: a. An unopened bottle of latanoprost eyedrops stored in the top drawer. The pharmacy label indicated to refrigerate before opening. b. A bottle of latanoprost eyedrop was open and not dated with an open date. The pharmacy label indicated, After Opening, May Store At Room Temperature. Throw Away Any Drug Left After 6 weeks. c. A bottle of nitroglycerin (used to treat episodes of chest pain) tablet had an expiration of 10/ [20]24, and had expired; d. A bottle of latanoprost eyedrop had an open date of 9/15/24. Upon review with LVN F, he confirmed it was good for six weeks after opening and was expired on 10/28/24; e. A Trelegy (medication to treat breathing problems such as asthma) inhaler was undated with the open date. A review of manufacturer's label indicated, to discard one month after opening. f. A fluticasone propionate (medication to treat breathing problems) diskus had an open date of 7/24/24. A review of the manufacturer's label with LVN indicated to discard 2 months after opening. LVN F confirmed it was good for two months after opening, and that it expired on 9/24/24. 3. During an inspection of the Station 3 medication cart on 11/13/24 at 11:03 a.m., with Licensed Vocational Nurse G (LVN G), LVN G confirmed the following findings: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A bottle of unopen latanoprost eyedrop was stored in top drawer, LVN G stated it should be in the refrigerator; b. A glucagon (an injectable medication for treating very low blood sugar) injection had an expiration of 08/21/24 and had expired; A review of facility's policy and procedure titled, Storage of Medications, revised 11/2020, indicated, .4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .7. Medication requiring refrigerators are stored in a refrigerator located in the drug room at the nurses' station or other secured location .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50135 Based on observation, interview, and record review, the facility failed to ensure staff competently carried out the functions of the food and nutrition services department according to facility policy and standards of practice when: 1. One dietary support staff did not know how to properly test the sanitizer in the red bucket (bucket containing sanitizer solution used for sanitizing food contact surfaces), and 2. Two dietary support staff members did not correctly demonstrate how to calibrate a thermometer used to test food temperatures These failures had the potential to expose residents to bacterial contamination, which could result in food borne illnesses for all residents who consumed food from the kitchen. Findings: 1. On 11/13/24 at 10:50 a.m., an observation and interview were conducted in the kitchen with the dietary manager (DM) and cook (Ck) P. Ck P stated she worked at the facility for [AGE] years. Ck P stated she checks the red bucket sanitizer solution every two hours. Ck P poured out the solution in the red bucket into the empty sink then scooped solution from the three-compartment sink filled with water and sanitizer. She stated the water and sanitizer was sitting in one of the three-compartment sinks for about three to four hours, but was not sure. Ck P placed a test strip into the solution in the red bucket while reading directions on the chart posted above the sink, then immediately compared the strip to the side of the strip canister's color chart. The test strip turned dark purple. Ck P stated it should be between 272 ppm -700 ppm (parts per million) according to the instruction chart. The DM verified the red bucket solution was not at the correct sanitizer concentration level and acknowledged Ck P did not test the sanitizer solution correctly. During a concurrent interview on 11/14/24 at 2:10 p.m., with the registered dietician (RD), she stated she did not teach how to test red bucket sanitizer with test strips. She stated, I didn't show them how to use the test strips but just told them it should be done every time the sanitation water is changed. 2. During a kitchen observation and interview on 11/13/24 at 10:58 a.m., with the DM, Ck P, and Ck Q, regarding thermometer calibration. DM stated, Our thermometers are about six months old. Ck Q was asked to demonstrate thermometer calibration. Ck Q began the thermometer calibration by placing a thermometer into a glass filled with ice and water. The glass was predominately filled with water. Ck Q stated he should wait for thermometer to reach 32 F. Ck Q verified thermometer temperature reached 38 F- 40 F. Ck P stated she knew how to calibrate the thermometer accurately so she placed a thermometer into a glass filled with ice and water and stated it should read 32 F. Ck P verified thermometer temperature reading of 38 F-40 F. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the undated thermometer manufacturer's guide indicated, Prepare a cup of ice with a small amount of water. Insert the stem into the water. Do not touch the bottom of cup. Temperature should read 32 F. During an interview on 11/13/24 at 11:01 a.m., with the RD, she stated she recently conducted in-services on thermometer calibration and kitchen sanitation to all kitchen staff and stated, Everyone did well. During a concurrent interview on 11/14/24 at 2:10 p.m., with the RD, she stated she did not teach how to test red bucket sanitizer with test strips during the in-services. She stated, I didn't show them how to use the test strips but just told them that it should be done. Review of the facility's Food & Nutrition Services In-Services from April 2024-November 2024, the in-service titled 3 Compartment Sink, Can Opener, Cutting Board, dated 9/19/24 indicated Ck P did not attend the in-service. The in-service titled, Thermometer, Calibration and MDSI Update, dated 11/7/24 indicated Ck P did not attend the in-service. The in-services were conducted in the format of lecture, discussion, review of spreadsheets and post-test. The in-services did not include any teach back methods from the dietary staff. Review of the facility's policy and procedure, Sanitation, dated November 2022, indicated, The food service area is maintained in a clean and sanitary manner. 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. 9. Service area wiping cloths are cleaned and sanitized per manufacturer's instructions. Review of the facility's policy titled, Sanitizer Bucket updated May 2024, indicated, Buckets should be changed every 2-4 hours or more as needed to keep the water clean and the sanitizer effective in use. Test solutions with test strips regularly to ensure that they are maintaining the proper strength of sanitizer for food contact surfaces. There are 3 factors that influence the effectiveness of chemical sanitizers: 1. Concentration- not using enough sanitizing agent will result in an inadequate reduction of microorganisms. Using too much sanitizing agent can be toxic . Review of the facility's job description titled Registered Dietitian, dated May 2024, indicated, Essential Duties . Monitor food services operations to ensure conformance to nutritional, safety, sanitation and quality standards, as well as state and federal regulations.

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	555444	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Gardens Post Acute	1150 Tilton Drive Sunnyvale, CA 94087

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure proper infection control practices were implemented when: 1. Certified nursing assistants did not perform hand hygiene in between residents' lunch tray set up; 2. Residents 8 and 107's oxygen concentrator's (a device which concentrates the oxygen from ambient air) filters were not changed and had some grayish substance build-up; 3. Residents 51, 59 and 18's nebulizer (a small machine that turns liquid medicine into a mist that can be inhaled directly into the lungs) mask and tubing were not properly stored when not in used; 4. Wound nurse (WN) did not change gloves in between wound treatment; 5. Staff did not perform proper hand hygiene during Resident 26's care; 6. Resident 45's oxygen humidifier was not changed in a timely manner and the gastric feeding tube port was on the floor uncovered; 7. Staff did not perform hand hygiene upon entering and exiting Resident 90 and Resident 122's room and in between resident's care; 8. Residents 114 and 111's oxygen tubings were dragging on the floor; 9. A Licensed Vocational Nurse did not place a barrier between a potentially contaminated object and the resident's overbed table and did not clean the table after performing the fingerstick blood sugar (FBS) check for Resident 36. 10. A Registered Nurse (RN) did not perform hand hygiene in between gloves changes during the medication administration. These failures had the potential to compromise resident's health and safety in the facility. Findings: 1.During meal pass observation on 11/12/2024 at 12:35 p.m., at the hallway, certified nursing assistant X (CNA X) was observed going inside Resident 59's room with Resident 59's lunch tray. CNA X was observed setting up Resident 59's lunch on her overbed table. CNA X went out of Resident 59's room without performing hand hygiene. At 12:39 p.m., CNA X poured coffee from a carafe to a cup, took Resident 8's lunch tray from the meal cart, placed the cup of coffee on Resident 8's lunch tray, and went inside Resident 8's room. CNA X was observed setting up Resident 8's lunch on her overbed table. CNA X went out of Resident 8's room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another observation on 11/12/2024 at 12:43 p.m., at the same hallway, certified nursing assistant Y (CNA Y) was observed coming out of Resident 54's room, touched her face, then went to the cart, prepared coffee for Resident 54 then took Resident 63's lunch tray from the food cart. CNA Y went inside Resident 63's room and set up her meals in the overbed table. CNA Y assisted Resident 63 to sit on her wheelchair and grabbed Resident 54's water pitcher without performing hand hygiene. CNA Y stepped out of the room still without performing hand hygiene to get some ice. At 12:47, CNA Y was back with a pitcher of ice and placed it on Resident 54's overbed table (Residents 63 and 54 were roommates). During a follow up interview with CNA Y on 11/12/2024 at 12:50 p.m., CNA Y confirmed above observations and stated, I should have performed hand hygiene in between residents' meal set up. During an interview with CNA X on 11/12/2024 at 12:55 p.m., CNA X confirmed observations at 12:35 p.m. and 12:39 p.m. CNA X stated she should have performed hand hygiene. During an interview with infection preventionist (IP) on 11/14/2024 at 10:06 a.m., IP stated hand hygiene should be performed in between residents' meal set up. IP further stated if staff touched any body parts of the resident, they should perform hand hygiene prior to touching another resident's meal trays. During a review of the facility's policy and procedure, Handwashing/Hand Hygiene, revised October 2018, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub containing at least alcohol; or alternately, soap (antimicrobial or non-antimicrobial and water for the following situations: . Before and after direct contact with residents . Before and after handling food . 2a. During an observation on 11/12/2024 at 10:24 a.m., inside Resident 8's room, Resident 8 was observed finishing up her breakfast, with oxygen at 4 liters (metric unit of capacity) per minute (LPM) thru nasal cannula (NC, a tubing used to deliver oxygen from the machine through the nostrils) connected to an oxygen concentrator. The oxygen concentrator's filter located at the right side was observed with some grayish substance build up. During a concurrent observation and interview with licensed vocational nurse J (LVN J) on 11/13/2024 at 10:21 a.m., LVN J confirmed above observation. LVN J stated she was not sure who was supposed to change the oxygen concentrator's filter. 2b. During an observation on 11/13/2024 at 9:25 a.m., inside Resident 107's room, Resident 107 was observed walking inside her room with oxygen at 3.5 LPM thru NC. The oxygen concentrator's filter located at the back had grayish substance build up. During a concurrent observation and interview with licensed vocational nurse G (LVN G) on 11/13/2024 at 9:32 a.m., inside Resident 107's room, LVN G confirmed above observation. LVN G stated the oxygen filter needed to be changed. LVN G further stated, she was not sure who needed to change the filter. During an interview with IP on 11/14/2024 at 1:55 p.m., IP stated the oxygen concentrator's filters should have been changed every seven days, on a Sunday and she checked them on weekdays. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3a. During an observation on 11/12/2024 at 9:56 a.m., inside Resident 51's room, Resident 51 was asleep in bed, her nebulizer mask was placed on top of the bedside drawer and the nebulizer tubing was dated 9/27/2024. During a concurrent observation and interview with LVN J on 11/13/2024 at 10:12 a.m., inside Resident 51's room, LVN J confirmed the nebulizer mask and tubing were still placed on top of the bedside drawer and it was still dated 9/27/2024. LVN J stated the nebulizer mask and tubing should be stored inside a bag when not in used and the whole nebulizer kit (mask and tubing) should be changed every 2 weeks. During another observation inside Resident 51's room on 11/14/2024 at 1:55 a.m., the nebulizer tubing was still dated 9/27/2024. 3b. During an observation on 11/12/2024 at 10:05 a.m., inside Resident 59's room, Resident 59 was seated in bed and observed her nebulizer mask and tubing were placed on top of the nebulizer located on top of Resident 59's bedside drawer. During a concurrent interview and photo review with LVN J on 11/13/2024 at 10:15 a.m., LVN J reviewed the photo of Resident 59's nebulizer mask and tubing were placed on top of the nebulizer. LVN J stated the nebulizer tubing and mask should be stored in a bag when not in use. 3c. During an observation on 11/12/2024 at 10:57 a.m., inside Resident 18's room, Resident 18 was in bed, holding on to her nasal cannula, and observed her nebulizer tubing was placed on top on the nebulizer while the mask was touching the top of bedside drawer. During an interview with IP on 11/14/2024 at 1:55 p.m., IP stated the nebulizer kit should be stored in a zip lock bag when not in use and it should be changed every 7 days. During another observation inside Resident 18's room on 11/15/2024 at 8:54 a.m., Resident 18's nebulizer kit was placed on top of the nebulizer with mask touching the bedside drawer. During an interview with director of nursing (DON) on 11/18/2024 at 11:29 a.m., DON stated staff should store the nebulizer kit in a plastic bag they provided when not in use. During a review of the facility's policy and procedure, Administering Medications through a Small Volume (Handheld) Nebulizer, revised October 2010, indicated, The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway . Rinse and disinfect the nebulizer equipment according to facility protocol . When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Change equipment and tubing every seven days, or according to facility protocol. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During wound treatment observation on 11/15/2024 at 1:36 p.m., inside Resident 29's room, wound nurse (WN) prepared the wound treatment supplies needed on a barrier on top of the overbed table. WN started to remove old dressing on Resident 29's sacrum, then WN started to clean the wound bed, without changing gloves. WN took a clean gauze, moistened it, and soaked the wound with it. While waiting for 5 minutes to soak the wound, WN rubbed Resident 29's back with dirty gloves. After 5 minutes, WN removed her dirty gloves, performed hand hygiene, and then started to apply foam dressing to Resident 29's lower back for protection and rubbed Resident 29's back again with the same pair of gloves. WN adjusted Resident 29's robe and then removed the moist gauze from Resident 29's sacrum wound with the same contaminated gloves and started to measure the wound. WN then changed her gloves, performed hand hygiene then wiped the sacrum wound with gauze, and followed the treatment order. During a follow up interview with WN on 11/15/2024 at 1:50 p.m., WN confirmed above observation. WN stated she felt bad for not changing her gloves when touching dirty dressings. WN further stated she should have changed her gloves and performed hand hygiene every time she touched a dirty area to a clean area. During an interview with DON on 11/18/2024 at 11:29 a.m., DON stated staff should know that they must change their gloves every time they touched a dirty area to a clean area. During a review of facility's policy and procedure titled, Handwashing/Hand Hygiene, date revised October 2018, indicated, The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 49345 5. During a concurrent observation and interview on 11/12/24 at 10:01 a.m. in Resident 26's room with certifed nursing assistant S, CNA S wore gloves and used a wet white washcloth to wipe Resident 26's face. CNA S then removed her gloves and put on a new pair. CNA S assisted Resident 26 to sit up, CNA S took off Resident 26's vest and long sleeve shirt and put on a long sleeves flannel shirt on Resident 26 and assisted him to lie back down. CNA S then took off her gloves and got a white washcloth from Resident 26's closet and wet it with water in the bathroom. CNA S put on new gloves, and then raised Resident 26's bed, she (CNA S) took off Resident 26's pants and socks, she then turned Resident 26 to the right side and removed his diaper, CNA S wiped Resident 26's buttocks with white wet washcloth, fecal (stool) matter was noted on the washcloth. CNA S threw the used washcloth in a plastic bag. CNA S then opened Resident 26's bedside drawer and took out a cream, she then put on a new diaper on Resident 26 and applied cream on Resident 26's buttocks and then closed the diaper. CNA S touched Resident 26's shirt, used the bed control buttons to lower the head of the bed and pulled up Resident 26. CNA S then removed her gloves and put on a new pair and went on to clean Resident 26's dentures. CNA S confirmed she did not do hand hygiene in between changing gloves and she did not change gloves and do hand hygiene after cleaning Resident 26's buttocks and removing his diaper with fecal matter. During an interview on 11/14/24 at 12:59 p.m. with the Infection Preventionist (IP), the IP stated hand hygiene should be done in between changing gloves. The IP also stated that staff must do hand hygiene and change gloves after handling a soiled diaper and before putting on a new diaper on a resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policies and procedures, Handwashing/Hand Hygiene, revised October 2018, indicated, . 7.Use an alcohol-based hand rub containing at least alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .h. Before moving from a contaminated body site to a clean body site during resident care; . m. after removing gloves . 6. During an observation on 11/12/24 at 11:02 a.m. in Resident 45's bedside, Resident 45 had on nasal cannula connected to an operating oxygen concentrator (a machine that uses air around you to make oxygen). The humidifier (a medical device that adds water vapor to supplemental oxygen to help prevent dry air from irritating the sinuses and throat) on the oxygen concentrator had a written date of 10/21/24. A disconnected gastric feeding tube (a tube connected through the belly that brings nutrition directly to the stomach) set in a feeding pump (a medical device that delivers gastric feeding and flushing to patients) was also noted by the bedside with the end port uncovered and exposed on the floor. During a concurrent observation and interview on 11/12/24 at 11:10 a.m. with licensed vocational nurse H, LVN H confirmed the gastric feeding tube end port on the floor without cap/cover. LVN H stated there is no cap to cover the port when it is disconnected. LVN H also stated the caps for tube feeding set were always discarded after opening. LVN H also confirmed the oxygen humidifier had a written date of 10/21/24. LVN H stated the humidifier is changed when it is empty. During an interview on 11/14/24 at 12:59 p.m. with the IP, the IP stated gastric feeding tube set comes with a cap and ports should always be covered when disconnected. The IP also stated that oxygen humidifier should be changed every 7 days. During a concurrent observation and interview on 11/14/24 at 2:00 p.m. with the Director of Nursing (DON), the DON confirmed their stock for gastric feeding set came with cap to cover the ports. The DON stated the ports should always be covered if disconnected from the resident. A review of facility's policies and procedures, Enteral Feedings- Safety Precautions, dated 2001, indicated, . 1. All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. 7. During a concurrent observation and interview on 11/18/24 at 11:06 a.m., Laundry Aide E (LA E) entered Resident 122's room, took Resident 122's call light button from the floor and clipped it on Resident 122's bed. LA E then went to Resident 122's roommate, Resident 90, LA E held Resident 90's call light button and asked if Resident 90 needs it. LA E exited the room. LA E confirmed she did not do hand hygiene upon entering the residents' room, after touching Resident 122's call light button and moving to Resident 90 and touching his call light button, and upon exiting the room. LA E also confirmed she did not sanitize Resident 122's call light button after picking it up from the floor and then clipping it on Resident 122's bed. LA E stated she should have used hand sanitizer upon entering and exiting the residents' room. A review of facility's policies and procedures, Handwashing/Hand Hygiene, revised October 2018, indicated, . 7.Use an alcohol-based hand rub containing at least alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident . 50135 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8a. Review of Resident 114's clinical record indicated Resident 114 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure with hypercapnia, acute pulmonary edema, and asthma with acute exacerbation. Review of Resident 114's Minimum Data Set (MDS, an assessment tool) dated 10/10/24 indicated her brief interview for mental status (BIMS, cognition level) score was 13 (13 to 15 points suggests that cognition is intact). Review of Resident 114's physician's order summary indicated to administer oxygen 3liters/minute (l/min, liters per minute) via nasal cannula (NC, a plastic tubing that delivers supplemental oxygen) continuously, starting on 9/1/24. During a concurrent observation and interview with Certified Nursing Assistant (CNA) O in Resident 114's room on 1/15/24 at 9:20 a.m., Resident 114 was awake and lying in bed with the NC and part of the oxygen tubing on the floor. CNA O confirmed this observation and stated the oxygen tubing should not be on the floor. 8b. A review of Resident 111's medical record indicated Resident 111 was admitted to the facility on [DATE] with diagnoses including respiratory disorders, pneumothorax (air leak into the space between the lungs and chest wall), other alveolar (tiny branches of air tubes in the lungs), and acute pulmonary edema (increased fluid in the lung). Review of Resident 111's MDS, dated [DATE] indicated his BIMS score was 3 (0-7 points suggests severe cognitive impairment). Review of Resident 111's physician's order summary indicated to administer oxygen at 2 liters/minute via nasal cannula continuously with start date 11/13/24. During a concurrent observation and interview in the room of Resident 111, on 11/15/24 at 9:14 a.m. with the Director of Nursing (DON), the DON confirmed the oxygen tubing of Resident 111 was dragging on the floor while Resident 111 was lying in his bed. The DON stated, If the tubing is long, it's ok to be on the floor as long as the part in the nose is not on the floor. The DON then pulled the oxygen tubing up off the floor and coiled the tubing together then placed it onto the head of Resident 111's bed. Review of the facility's policy and procedure Infection Prevention and Control Program, dated October 2019, indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, 4. The elements f the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance . prevention of infection .11. Prevention of Infection a. Important facers of infection prevention include: (1) identifying possible infections . (3) educating staff and ensuring that they adhere to proper techniques and procedures. 50855 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. During an observation on 11/12/24 at 12:21 p.m., Licensed Vocational Nurse H (LVN H), was doing the fingerstick blood sugar (FBS) check for Resident 36. After done, LVN H placed the glucometer (an instrument for measuring blood sugar) on Resident 36's overbed table without placing a barrier (such as a clean paper towel) first, and did not clean the table after. During an interview shortly after the observation, on 11/12/24 at 12:27 p.m., LVN H was asked if he should have placed a barrier on the table before placing the glucometer on Resident 36's overbed table after he used it, LVN H stated he did not placed a barrier and he usually does not clean the table after use. During a follow up interview on 11/12/24 at 3:28 p.m., with LVN H, he stated the Director of Nursing (DON) advised he should have put a barrier between the glucometer and resident's overbed table and sanitized the table after. 10. During the medication administration observation on 11/12/24 at 4:21 p.m., RN L was observed putting on a pair of gloves before administering medication to Resident 64's gastric tube (G-tube, a tube that goes directly into the stomach to deliver feeding formula and medications). RN L administered 2 medications, removed her pair of gloves, and went outside of Resident 64's room. In a short moment, RN L came back in Resident 64's room with blood pressure machine, took Resident 64's blood pressure, touched Resident 64's right arm, and donned a new pair of gloves to administer the remaining medications without performing hand hygiene. During an interview on 11/12/24 at 4:40 p.m., with RN L, when asked if she performed hand hygiene in between gloves changes, RN L stated she forgot to perform hand hygiene. She stated she should have washed her hands in between gloves changed. During an interview on 11/13/24 at 9:42 a.m., with the DON, she stated, They [nurses] need to sanitize hands in between and before applying new gloves. During a review of facility's policy and procedure, Handwashing/Hand Hygiene, revised October 2018, indicated, . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .7. Use of alcohol-based hand rub containing at least alcohol; or, alternative, soap a (antimicrobial or non-antimicrobial) and water for the following situations . b. Before and after direct contact with residents; c. Before preparing and handling medications . i. After contact with a resident's intact skin . 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hygiene is recognized as the best practice for preventing healthcare-associated infections .

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on observation, interview, and record review, the facility failed to ensure implementation of their Antibiotic (medication infection) Surveillance (timely collection, analysis, and communication of data) protocol when antibiotic use for two (Resident 111 and Resident 331) out of three sampled residents whey they were not monitored and tracked. This failure had the potential to place residents at risk for a development of antibiotic resistance (when bacteria change to resist antibiotics that once effectively treated them). Findings: During an observation of Resident 331 on 11/12/24 at 9:26 a.m. in Resident 331's room, a PICC (peripherally inserted central catheter, a thin flexible tube that is inserted into a vein in the upper arm used to deliver medications and other treatments) line was noted in Resident 331's right upper arm. Resident 331's left foot was observed to be covered with elastic bandage with a drainage tubing connected to a wound vacuum (a suction device that is applied after a wound is dressed). A review of Resident 331's clinical record indicated an admitted [DATE]. It also included a diagnosis of but is not limited to Acute [sudden] osteomyelitis [infection of the bone], left ankle and foot. A review of Resident 331's Physician Order, dated 11/5/24, indicated, Ampicillin-Sulbactam Sodium Intravenous [medicine is given through a vein] Solution Reconstituted [dissolved medication into a fluid for administration] 3 (2-1) GM [gram, a unit of measurement] (Ampicillin & Sulbactam Sodium); Use 3 gram intravenously every 12 hours for left foot osteomyelitis for 35 Days. During a concurrent interview and record review on 11/14/24 at 12:59 p.m. with the Infection Preventionist (IP), the IP stated that her morning routine is to check all the residents with new antibiotic usage and document on the antibiotic surveillance form (Infection Control Log). The IP verified that Resident 331 started intravenous antibiotic since 11/5/24 and this was not documented in the November 2024 Infection Control Log. A review of Resident 111's clinical records indicated an admitted [DATE]. It also indicated diagnosis of, but is not limited to, alcoholic liver cirrhosis (a type of liver damage that occurs when liver cells die and are replaced by scar tissue due to chronic alcohol consumption). A review of Resident 111's Physician Orders dated 7/3/24 indicated, Bactrim DS [double strength] Oral tablet 800-160 mg [milligram, unit of measurement] (Sulfamethoxazole- Trimethoprim) Give 1 tablet by mouth one a time a day for SBP [spontaneous bacterial peritonitis, a common infection in people with advanced liver disease] prophylaxis [an attempt to prevent disease]. A review of Resident 111's Physician Orders dated 10/01/24 indicated, Rifaximin Oral 550 MG Give 1 tablet by mouth two times a day for hepatic [relating to the liver] encephalopathy [a change in brain function due to injury or disease]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/15/24 at 11:15 a.m. with the Director of Nursing (DON) and the IP, the IP and the DON verified Resident 111 was on the antibiotic medications Bactrim DS and Rifaximin. The IP and the DON also verified that Resident 111's use of Bactrim DS was logged on the July 2024 Infection Control Log and not in August 2024, September 2024, October 2024, and November 2024. The IP and the DON also verified that Resident 111's use of Rifaximin was logged on the October 2024 Infection Control Log and not in November 2024. A review of facility's policies and procedure, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, indicated, .4. All resident antibiotic regimen will be documented on the facility antibiotic surveillance tracking form .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555444	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Gardens Post Acute	1150 Tilton Drive Sunnyvale, CA 94087

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38087 Based on observation, interview, and record review, the facility failed to ensure call lights were properly functioning and accessible for four sampled residents (Resident 97, 104, 122, and 232) when: 1. Resident 232 's call light was not in reach while in bed; 2. Resident 97 and Resident 104's call lights were not functioning; and, 3. Resident 122's call light was not within reach while in bed. These failures could prevent residents from communicating with staff for basic needs and in emergency situations, which could potentially compromise the resident's care and safety. Findings: 1. Review of Resident 232's minimum data set (MDS, an assessment tool) dated 11/1/24, indicated he required supervised assistance by staff for bed mobility, dressing, toileting, bathing, and personal hygiene. Resident 232 required moderate assistance for toilet transfers and chair to bed transfers. During an observation in Resident 232's room on 11/12/24 at 12:49 p.m., Resident 232 was lying in the bed and his call light was on the floor under his bed, out of reach of Resident 232. During an interview with licensed vocational nurse A (LVN A) on 11/12/24 at 12:55 p.m., she confirmed the above observation. LVN A stated that Resident 232's call light was entangled with the bed/TV control and had fallen to the ground. LVN A stated all residents should have call lights within reach at all times. 50135 2a. Review of Resident 97's admission record indicated she was admitted to the facility on [DATE] with diagnoses including Charcot's Joint (disease that causes the destruction of joints and bones), age-related osteoporosis (a bone disease that causes bones to become weak), fracture of left femur (thigh bone), and difficulty walking. Review of the most recent MDS (Minimum Data Set, an assessment tool) dated August 22, 2024, indicated Resident 97 required the use of a walker and wheelchair and required partial to moderate assistance with upper and lower body dressing. During an observation and interview on 11/12/24 at 10:28 a.m. with Resident 97, Resident 97 was sitting in her wheelchair in her room. Resident 97 stated her call light up on the wall panel mounted on the wall behind her bed, so she did not know if the light worked in the hallway to indicate she needed assistance. Resident 97 stated she told staff her call light was not working but had not been fixed and had not been working for two weeks. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 11/12/24 at 10:38 a.m. with Certified Nursing Assistant (CNA) R in the room of Resident 97, CNA R verified Resident 97's call light did not light up in her room and did not light up in the hallway that indicated she needed help. During an interview on 11/12/24 at 1:40 p.m., the maintenance director (MD) indicated there had been issues with Resident 97's call light not working and he was working on it. During an observation and concurrent interview, on 11/13/24, at 10:08 a.m., Resident 97 demonstrated that her call light did not work. She stated she talked to the maintenance worker, but the light was not fixed. 2b. Review of Resident 104's admission record indicated she was admitted to the facility on [DATE] with diagnoses including cerebral palsy (a group of neurological disorders that permanently affect body movement and muscle coordination), cerebellar stroke (blockage or bleeding in the brain) syndrome, abnormal posture, generalized muscle weakness, spastic hemiplegia (abnormal brain development that causes muscle tightness on one side of the body), neuralgia (pain caused by damaged or irritated nerves), and neuritis (inflammation of a nerve or nerves). Review of the most recent MDS dated [DATE], indicated Resident 104 was Dependent in all mobility activities. The MDS indicated the resident had functional limitation in range of motion in both lower extremities. During an observation and interview on 11/12/24 at 10:35 a.m. in the room of Resident 104, Resident 104 was sitting up in her bed and stated sometimes her call light doesn't light up on the wall panel over the past month. Resident 104 stated she reported it to the staff, and she spoke to the maintenance director who told her he would have to change the wall panel, but he never replaced it. Resident 104 stated she must ask her roommate to press her call light if she needs assistance. During an interview on 11/12/24 at 1:42 p.m. with MD, he stated he was working on the call light for Resident 104 and stated he was working on replacing the entire wall panel for the special bed that Resident 104 had, but he had not finished repairing it. During a concurrent interview on 11/14/24 at 9:20 a.m. in the room of Resident 104, Resident 104 stated her call light was fixed on 11/14/24 by the MD. She stated the entire wall panel was replaced by the MD and stated, It now lights up. Review of the facility's undated policy, Answering the Call Light, indicated The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines: 7. Report all defective call lights to the nurse supervisor promptly. Review of the facility's job description for the Director of Maintenance, dated August 2016, indicated The Director of Maintenance Responsibilities- Maintains electrical and mechanical equipment in good working order; Adjusts functional parts of devices and control instruments . as needed. Reports serious failures and problems to the Administrator. 49345 (continued on next page)

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