

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2024
NAME OF PROVIDER OR SUPPLIER  Sunnyvale Post-Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1291 S Bernardo Avenue Sunnyvale, CA 94087	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42819</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse involving two of two sampled residents (1 and 2) to the appropriate agencies, including the State Survey Agency. This failure to report potentially compromised residents' safety in the facility and violated mandated reporting requirements.</p> <p>Findings:</p> <p>Review of the intake information dated 6/17/24, indicated Resident 1's roommate (Resident 2) allegedly threw a fan onto Resident 1's chest.</p> <p>During a telephone interview with Resident 1's family member (FM) on 6/17/24 at 4:30 p.m., the FM stated Resident 2 had thrown a fan at Resident 1 on the night of 6/16/24. The FM further stated the incident was reported to the charge nurse on duty.</p> <p>On 6/18/24, an unannounced visit was conducted at the facility to investigate a complaint regarding a resident-to-resident alleged abuse.</p> <p>Review of Resident 1's admission record dated 6/19/24, indicated Resident 1 was admitted on [DATE] with a primary diagnosis of infection and inflammatory reaction due to other cardiac and vascular devices (infection after a person has received medical devices or implants in their heart or blood vessels. These devices includes, pacemakers, heart valves, or stents).</p> <p>Review of Resident 1's minimum data set (MDS, an assessment tool) dated 6/17/24, indicated Resident 1 had a brief interview for mental status (BIMS) score of 7, indicating severe impaired cognition.</p> <p>Review of Resident 2's admission record dated 6/19/24, indicated Resident 2 was admitted on [DATE], with the diagnoses of acute transverse myelitis in demyelinating disease of central nervous system (a condition where the spinal cord becomes inflamed, causing weakness, numbness, or paralysis), post-traumatic stress disorder (mental health condition that can develop after someone experiences a traumatic event), unspecified mood disorder (a mental health condition characterized by changes in mood).</p> <p>Review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS score of 14, indicating cognition was intact.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's Nursing Progress Notes, dated 6/17/24, indicated, 2345 Routine care safety rounds made and resident observed sitting at side of bed; seemed anxious as this resident look on a small battery operated electric fan that is on the floor by the side of bed; offered if this writer could pick up the fan device for storage but refused .asked if the fan device is her own but shook own head, suggesting that it's not hers; this resident pointed her own fingers towards the room mate. Per outgoing nursing staff, resident may have called own family who are now on their way to check on resident. 0030 Resident's 3 daughters now at bedside and asked this writer to transfer resident to another room for resident still have difficulty getting along with the room mate. Inquired to room mate re ownership of the fan device that's on the floor, room mate acknowledged that the fan is hers; that own fan device place at the bedside table suddenly fell down the floor.</p> <p>During an interview with the social services director (SSD) on 6/18/24, at 12:49 p.m., the SSD stated he knew about the alleged incident from facility's staff on the morning of 6/17/24. He stated the staff informed him about a commotion during the night shift in the room shared by Residents 1 and 2. The SSD stated the FM also informed both him and the DON the morning after the alleged incident that Resident 2 had thrown a fan at Resident 1. However, the SSD stated the incident was not reportable because Resident 2 denied the action, claiming that the clip-on fan, attached to her bed rail, tends to fall when bumped. The SSD stated it was a disagreement between the two residents.</p> <p>During an interview with Resident 2 on 6/18/24, at 1:15 p.m, Resident 2 stated that she did not throw the fan at Resident 1. She stated that the fan was attached to her bed's side rails and likely fell on the floor. Resident 2 stated she was not physically capable of throwing objects and was asleep at that time of the incident.</p> <p>During a phone interview with registered nurse A (RN A) on 8/6/24, at 2:46 p.m., RN A, who was the night shift charge nurse for Residents 1 and 2 on 6/16/24, stated that Resident 1 called her family to report that Resident 2 had thrown a fan at her. RN A stated that Resident 1's FM informed him that Resident 1 believed the fan was intentionally thrown by Resident 2. RN A immediately reported the incident to the DON.</p> <p>During an interview with the DON on 8/7/24, at 2 p.m., the DON stated RN A called her on the night of 6/16/24 and reported that Resident 1 had complained about a fan that had rolled onto the floor. The DON stated that it was not reported to her that Resident 2 had intentionally thrown the fan at Resident 1. The DON stated if the act had been intentional, it should have been reported to the State agency. The DON stated the Administrator (ADM) initiated an internal investigation, which included interviews with staff and both residents. According to their investigation, Resident 2 stated she was asleep at the time and did not have the capacity to throw the fan at Resident 1, which led to the decision not to report the incident to the State agency.</p> <p>During an interview with the ADM on 8/8/24, at 4:06 p.m., the ADM, who also serves as the abuse coordinator, stated that that on 6/17/24, he received a report from the nurses that Resident 2 allegedly threw a fan at Resident 1. The ADM stated that they conducted an investigation and found that Resident 2 was asleep at that time, and the fan was not broken . The administrator stated that they only report to the State agency if an actual abuse situation occurs. In this case, since no harm resulted from the incident, they decided not to report it.</p> <p>(continued on next page)</p>		

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