STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555792	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Post-Acute Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care and services were provided in accordance with professional standards of practice for one of three residents (Resident 1) when the facility did not administer medication as ordered by a physician for Resident 1. This failure had the potential to compromise the resident's health and care.Review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted on [DATE] and had diagnoses including essential hypertension (HTN-high blood pressure), hypotension (low blood pressure), and epilepsy (an abnormal activity in the brain causing seizures [uncontrollable jerking movements of the arms and legs, and loss of consciousness]). Review of Resident 1's physician's order, dated 5/7/25, indicated Losartan Potassium (a hypertension medication) 25 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), give 1 tablet by mouth one time a day for hypertension, hold for SBP (systolic blood pressure) less than 100. Review of Resident 1's May 2025 Medication Administration Record (MAR) indicated Losartan Potassium 25 mg tablet was administered from 5/8/25 to 5/15/25. There was no documentation indicating BP was checked and SBP was greater than 100 when administering Losartan Potassium to Resident 1 on the MAR from 5/8/25 to 5/15/25. Review of Resident 1's Change in Condition Evaluation, effective date 5/15/25, indicated the patient began having a seizure and became unresponsive and was staring at the ceiling. The patient had a BP of 80/54. Resident headed to [hospital name] for further evaluation. During an interview and record review with Licensed Vocational Nurse (LVN) A on 5/29/25 at 3:05 p.m., he confirmed the above record review. LVN A confirmed that he administered Losartan Potassium to Resident 1 on 5/12/25 and 5/15/25. LVN A stated there was no documentation indicating BP was checked and SBP was greater than 100 when administering Losartan Potassium to Resident 1 on 5/12/25 and 5/15/25. LVN A acknowledged that Resident 1's BP should have been checked prior to administering Losartan Potassium as ordered and documented. During an interview and record review with the Director of Nursing (DON) on 7/11/25 at 10:45 a.m., she confirmed the above record review. The DON stated Resident 1's BP was checked every shift but there was no evidenced documentation indicating BP was checked and SBP was greater than 100 when administering Losartan Potassium to Resident 1 from 5/8/25 to 5/15/25. The DON acknowledged that Resident 1's BP should have been checked prior to administering Losartan Potassium as ordered and documented. Review of Resident 1's Discharge Summary from the hospital, dated 5/18/25, indicated Principle Diagnosis at discharge: Syncope and collapse (fainting, or a sudden temporary loss of consciousness). During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 11. The following information is checked/verified for each resident prior to administering medications: b. Vital signs, if necessary.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	555792	A. Building B. Wing	07/11/2025

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of accidents and hazards for one of three sampled residents (Resident 1) when: 1. Resident 1 was not accurately assessed for Fall Risk Observation/Assessment and Admission/readmission Evaluation/Assessment; and 2. Staff did not assist Resident 1 during toileting and left Resident 1 unsupervised inside the resident restroom. These failures resulted in Resident 1's unwitnessed fall.Review of Resident 1's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted on [DATE] and had diagnoses including essential hypertension (HTN-high blood pressure), hypotension (low blood pressure), epilepsy (an abnormal activity in the brain causing seizures [uncontrollable jerking movements of the arms and legs, and loss of consciousness]), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a symptom that involves the loss of the ability to move on one-side of body) following cerebral infarction (stroke), muscle weakness, and difficulty in walking. Review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 5/9/25, indicated a brief interview for mental status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was scored 12 (which indicates moderate cognitive impairment). Resident 1 had an impairment on one side of upper/lower extremity and required partial/moderate assistance (helper does less than half the effort) for toileting hygiene and toilet transfer. Review of Resident 1's Fall Risk Observation/Assessment, dated 5/7/25, indicated Score of 14 (Moderate Risk 9-15). The assessment indicated, 3. Balance and 6. Mobility were marked at 1. Ambulates without problem and with devices. Review of Resident 1's Admission/readmission Evaluation/Assessment, dated 5/7/25, indicated, K. Ambulation: ambulatory with 1 person assist, needs 1 person assist with transfer; M. Other relevant concerns: 4b. seizure precautions was marked at 2. No. Review of Resident 1's Rehab-Functional Abilities, effective date 5/8/25, indicated, Resident 1 required partial/moderate assistance for toileting hygiene and toilet transfer. Review of Resident 1's Occupational Therapy Treatment Encounter Note, dated 5/12/25, indicated, Toileting: toilet/commode transfers = minimum assist; personal hygiene = moderate assist; clothing management = moderate assist. Review of Resident 1's Change in Condition Evaluation, effective date 5/13/25, indicated Heard resident calling out loud ‘help me'. found lying down at floor, stated ‘I slid down from the commode'. able to ambulate to the bathroom using own FWW (front wheel walker) with one person assist. Review of Resident 1's Intradisciplinary team (IDT, a coordinated group of experts from several different fields who work together toward a common business goal) note, dated 5/15/25, indicated IDT met re: fall, Resident found lying down at floor, stated ‘I slid down from the commode'. Noted resident is mod A (moderate assist) for bed mobility, transfer and ambulation . During an interview and record review with the Director of Rehabilitation (DOR) on 5/29/25 at 4 p.m., she confirmed the above record review. The DOR verified licensed nurse did not accurately assess Resident 1 for the Fall Risk Observation/assessment dated [DATE]. The DOR stated Resident 1 was ambulating with problems and with devices, needed one person assistant. During a telephone interview with Registered Nurse (RN) B on 6/2/25 at 8:17 a.m., he confirmed he was Resident 1's nurse on 5/13/25. RN B stated Resident 1's unwitnessed fall was reported by a Certified Nursing Assistant (CNA). RN B stated the CNA assisted Resident 1 to the bathroom and left the room. During a telephone interview with CNA C on 7/11/25 at 10:15 a.m., he confirmed he was Resident 1's CNA on 5/13/25. CNA C stated he assisted Resident 1 into the bathroom, and Resident 1 asked him to close the bathroom door, and wait outside of the bathroom. CNA C stated he left her alone in the bathroom to answer a call light from another resident. CNA C stated Resident 1 was found on the bathroom floor when he came back. During an interview and record review with the Director of Nursing (DON) on 7/11/25 at 11:10 a.m., she confirmed the above record review and stated Resident 1 required one person assistant with her toileting. The DON acknowledged staff should have stayed nearby to provide partial/moderate assistant to Resident 1 during toileting. During an interview and record review with the DON on 7/11/25 at 11:30 a.m., she confirmed the above record review. The DON verified the licensed nurse did not accurately assess Resident 1 for the Fall Risk Observation/assessment dated [DATE]. The DON stated Resident 1 was ambulating with problems and with devices. During an interview and record review with the DON on 7/11/25 at 11:41 a.m., she confirmed the above record review. The DON verified the licensed nurse did not accurately assess Resident 1 for the Admission/readmission Evaluation/assessment dated [DATE]