

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  09/11/2025
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)
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<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> Based on interview and record review the facility failed to follow their abuse reporting policy and procedure for one of three sampled residents (Resident 1). This failure had the potential to compromise Resident 1's safety. Findings: During an interview with the Director of Nursing (DON) on 7/10/25 at 10:06 a.m., the DON had been notified of an allegation of abuse. During an interview with Resident 2 on 7/10/25 at 10:16 a.m., Resident 2 was sitting on his wheelchair and stated that on 6/25/25 around 3 a.m., to 5 a.m., a male CNA was rough when changing his roommate's (Resident 1) incontinent brief and he reported the incident to the nurse. During an interview with Resident 2 on 7/10/25 at 2:15 p.m., Resident 2 stated that on 6/25/25 he reported the alleged rough handling of Resident 1 to the woman medication charge nurse. Resident 2 further stated he was asked what exactly happened. Review of Resident 2's clinical records he was admitted to the facility on [DATE] with diagnosis including post-traumatic stress disorder (a mental health condition that develops after experiencing or witnessing a traumatic event). Resident 2's minimum data set (MDS, an assessment tool) dated 5/5/25 indicated his 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 (score of 15 indicates cognition [ability to remember, judge and use reason] is intact). During an interview on 7/17/25 at 10:56 a.m., with Certified Nursing Assistant B (CNA B), CNA B acknowledged that he was the CNA assigned for Resident 1 at night shift on 6/25/25. CNA B stated that he did not roughly handle Resident 1 during incontinent brief change. CNA B denied that Resident 2, the roommate of Resident 1, notified the charge nurse about a CNA roughly handling Resident 1 during incontinent brief change. During an interview on 7/23/25 at 2:25 p.m., with Licensed Vocational Nurse A (LVN A), LVN A stated that she was the full-time charge nurse working night shift for Resident 1 and did not observe or there was no report of any suspicious of abuse to Resident 1 on 6/25/25. LVN A denied that Resident 2 the roommate of Resident 1 notified her about a CNA that roughly handle Resident 1 during incontinent brief change. During an interview with the DON on 8/13/25 @ 12:27 p.m., the DON stated that the allegation of abuse was not brought to her attention by LVN A and CNA B that was interviewed by CDPH on 7/17/25 and 7/23/25. The DON further stated if they were notified by anyone other than California Department of Public Health (CDPH) they would have reported it to CDPH, Ombudsman (long term care ombudsman. representatives that assist residents in the long term care facilities with issues related to day to day care, health and safety concerns) and Police. During a review of the facility's policy and procedure (P&amp;P) titled, Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating, dated 2001. The P&amp;P indicated, .1. If Resident Abuse, Neglect, Exploitation, misappropriation of resident property, or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</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
-----------------------------------------------------------------------	-------	-----------

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  09/11/2025
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS, an assessment tool) for one of three sampled residents (Resident1) when Resident 1's ability to hear was not coded on the MDS.Failure to accurately complete the MDS had the potential to compromise the facility's ability to develop and implement care plan interventions.Findings:During a concurrent observation and interview on 7/10/25 at 10:10 a.m., with Resident 1 in his room, surveyor asked Resident 1 a question three times before Resident 1 responded. Resident 1 was observed with no hearing aid.During an interview on 7/17/25 at 10:56 a.m., with Certified Nursing Assistant B (CNA B), he stated that Resident 1 was hard of hearing and does not have hearing aid.During an interview on 7/23/25 at 2:20 p.m., with Licensed Vocational Nurse A (LVN A), she stated that Resident 1 was hard of hearing and does not wear hearing aid.Review of Resident 1's medical record indicated he was admitted to the facility on [DATE] with diagnoses which included muscle weakness, need for assistance with personal care, bilateral (both) sensorineural hearing loss (a condition where there is damage to the inner ear or the auditory nerve. During an interview and concurrent record review with Minimum Data Set Coordinator (MDSC) on 7/10/25, at 2:53 p.m., MDSC reviewed Resident 1's MDS, dated [DATE], and confirmed section B0200 was coded 0, indicating Resident 1's ability to hear was adequate. MDSC confirmed section B0200 should have been coded 3, to indicate Resident 1's highly impaired hearing and with diagnosis of bilateral sensorineural hearing loss.The Centers for Medicare &amp; Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions), dated 10/2024, indicated for section B0200, Code 3, for highly impaired hearing.</p>		

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  09/11/2025
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 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview, and record review, the facility failed to ensure garbage was disposed properly when one of three facility garbage was overflowing. This failure had the potential to result in the spread of disease from vermin infestation and unsanitary environment for the residents. Findings: During an observation on 7/10/25 at 12:07 p.m., at the back of the parking area, there was an uncovered, blue bin with overflowing garbage positioned at the back door of the facility. During an interview on 7/10/25 at 1:58 p.m. with the infection control preventionist (IP), the IP verified that the garbage was overflowing from the blue bin and not covered. The IP mentioned that the garbage bin must be closed and should not be overflowing. A review of undated facility's policy and procedure (P&amp;P) titled Food- Related Garbage and Rubbish Disposal indicated that All garbage and rubbish containers shall be provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use.</p>		