

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/02/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055737	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/20/2025
NAME OF PROVIDER OR SUPPLIER SUNNY HILLS POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 12200 LA MIRADA BLVD. LA MIRADA, CA 90638		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of one complaint. Complaint Number: CA00963039 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for complaint number CA00963039 (Refer to Ftag F757).	F 000	Sunny Hills Post Acute submits this response and Plan of Correction as part of the requirements under state and federal law. The plan of correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action of proceedings against the provider or its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party.	5/24/25	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 757			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *6/4/25*

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.

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F 757	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) did not receive medication that is greater than the recommended dose by the manufacturer's label, and accepted standards of practice for a resident 's condition.</p> <p>This deficient practice had potential to cause adverse reactions and medical complications for Resident 1.</p> <p>Findings</p> <p>During a review of Resident 1 ' s Admission Record dated 5/20/2025, the Admission Record indicated Resident 1 was originally admitted to the facility on 4/19/2021 and readmitted on 2/3/2022. The Admission Record indicated Resident 1 ' s diagnoses included diabetes mellitus (DM- a condition characterized by difficulty in blood sugar control and poor wound healing), other specified disorders of bone density and structure (a variety of conditions that affect bone strength), and muscle weakness (when muscles are not as strong as they should be).</p> <p>During a review of Resident 1 ' s History and Physical (H&P) dated 1/9/2025, the H&P indicated Resident 1 was not able to make medical decisions.</p> <p>During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool) dated 2/19/2025, the MDS indicated Resident 1 was usually able to understand and be understood by others. The MDS indicated Resident 1 required set up assistance to substantial/maximal</p>	F 757	<p>Corrective action for residents found to have been affected by this deficiency:</p> <p>-The Physician and / or NP of resident # 1 was notified of the medication administration error on May 18, 2025, and order was clarified.</p> <p>- The Physician was contacted on May 18, 2025, and labs were ordered for resident # 1 to rule out any abnormality. Resident's Calcium level was normal, and no other abnormalities were noted. Order was also obtained for monitoring of Dysphagia.</p> <p>-DON provided 1:1 education with the licensed nurse on May 19, 2025.</p> <p>Identification of others at risk:</p> <p>-DON and/or Designee audited residents with Alendronate 70 mg on May 20, 2025, and no other resident was affected by this practice.</p>	5/20/25
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F 757	<p>Continued From page 2</p> <p>assistance (staff does more than half the effort) for Activities of Daily Living (ADLS) such as bed mobility (the ability to roll from lying on back to left and right side and return to lying on back on the bed), transfers and walking.</p> <p>During a review of Resident 1 ' s Radiology Report dated 5/14/2025, the Report indicated Resident 1 had generalized osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) with degenerative disc space narrowing at all lumbar levels (a condition where the cartilage in the spine joints begin to wear out) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) change of the left hip joint.</p> <p>During a review of Resident 1 ' s Physician Order dated 5/14/2025, the Order indicated to administer Alendronate Sodium (a medication that slows the breakdown of bone and prevents the loss of calcium) 70 milligrams (mg-unit of measurement) 1 tablet by mouth in the morning for osteoporosis to Resident 1.</p> <p>During a review of Resident 1 ' s Order Progress Note dated 5/14/2025, the Progress Note indicated the order for Alendronate Sodium was outside the recommended dose or frequency. The Progress Note indicated Alendronate Sodium oral tablet 70 mg. one tablet by mouth daily exceeded the usual dosing regimen of 0.5 tablet every seven days to 0.67 tablet daily.</p> <p>During a review of Resident 1 ' s Medication Administration Record (MAR) dated 5/2025, the MAR indicated Alendronate Sodium oral tablet 70 mg one tablet by mouth was administered to Resident 1 on 5/15/2025, 5/16/2025, and</p>	F 757	<p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>-Starting on May 19, 2025, the Director of Nursing initiated in-service with Licensed Nurses on the facilities policy titled "Medication Errors" and "Medication Administration."</p> <p>Med Pass competency was initiated by the DON/Designee on May 29, 2025, and will be continued by the DSD/Designee on med pass observation to at least one (1) licensed nurse per month for three (3) months. Findings will be reported to the Director of Nursing for follow up.</p> <p>-Pharmacy Nurse Consultant will perform med pass observation during their monthly scheduled visit. Findings will be reported to the Director of Nursing for follow up.</p> <p>How the facility plans to monitor its performance to make sure that solutions are sustained</p> <p>The Director of Nursing will review all new residents with Alendronate orders to ensure orders are transcribed accurately for three (3) months.</p> <p>The Director of Nursing will provide a summary trend analysis of the facility compliance on a monthly basis x 3 months to the QA committee for further evaluation and recommendations until substantial compliance is sustained.</p>	

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F 757	<p>Continued From page 3 5/18/2025.</p> <p>During a review of Resident 1 ' s Change of Condition (COC) dated 5/18/2025, the COC indicated. Alendronate 70 mg was ordered to be given every week on Saturdays but was entered as Alendronate 70 mg by mouth daily and Resident 1 was given Alendronate 70 mg on 5/15/2025, 5/16/2025, and 5/18/2025.</p> <p>During an interview on 5/20/2025 at 9:35 a.m. with Resident 1, Resident 1 stated she received new medication for osteoporosis and was supposed to take it weekly, but the nurses (not specified) administered it to her (Resident 1) twice last week.</p> <p>During a concurrent interview and record review on 5/20/2025 at 11:20 a.m. with the Director of Nursing (DON), Resident 1 ' s order Progress Note dated 5/14/2025 was reviewed. The DON stated licensed nurses should have caught the medication order alert sooner indicating the Alendronate Sodium exceeded the usual dosage and clarified the order with the NP or physician.</p> <p>During an interview on 5/20/2025 at 2:07 p.m. with the pharmacist (Pharm 1), Pharm 1 stated Alendronate Sodium 70 mg should be given once a week and not daily. Pharm 1 stated the pharmacy only sent four tablets so it should have alerted the nurses that the medication was for weekly and not daily dosing. Pharm 1 stated the medication packaging also had instructions for weekly dosing. Pharm 1 stated taking Alendronate over the recommended once weekly dose could cause overdosing and lead to constipation (problem passing stool), diarrhea (loose watery stool), abdominal pain, headache,</p>	F 757			

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F 757	<p>Continued From page 4 and muscle cramps.</p> <p>During a concurrent record review and interview on 5/20/2025 at 3:25 p.m. with Registered Nurse (RN) 1, Resident 1 ' s Order Progress Note dated 5/14/2025 was reviewed. RN 1 stated she did not notice the medication alert on 5/14/2025 indicating the Alendronate Sodium dose for Resident 1 exceeded the usual dosing. RN 1 stated, if she had noticed the alert, she would have contacted the NP immediately to clarify the order. RN 1 stated, she became aware of the dosage error and reached out to the NP to clarify the order on 5/18/2025. RN 1 stated, the NP informed her, the Alendronate Sodium was supposed to be administered weekly (not daily) to Resident 1.</p> <p>During a concurrent observation and interview on 5/20/2025 at 4:00 p.m. with the DON, Resident 1 ' s Alendronate Sodium medication packaging/box was observed. The DON stated the medication packaging/box indicated the medication was to be given once weekly and nurses should have been aware of the instructions and administer the medication once weekly to Resident 1.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, "Medication Errors," dated 12/19/2022, the P&P indicated the facility would ensure medications would be administered according to physician orders, per manufacturer ' s specifications regarding the preparation, and administration of the drug or biological, and in accordance with accepted standards and principles which apply to professionals providing services.</p>	F 757			