STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555792	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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** Based on observation, interview, and record review the facility failed to ensure dignity for one out of 18 sampled residents (Resident 14), when the facility failed to provide privacy during cares. This failure resulted in the resident, who was partially uncovered, being visible to anybody walking by his room. Findings: During a review of the Resident 14's clinical record, indicated Resident 14 had [DIAGNOSES REDACTED]. During an observation on 3/10/2020 at 9:40 a.m., while walking in the hallway pass Resident 14's door, Resident 14 was observed lying on his bed in his room, with the curtain pulled back. Additionally, in full view of the hallway, the Resident was observed with his legs uncovered and his incontinence brief (a type of brief worn that helps to protect against incontinence or accidental urination and urine leakage) was visible. During an interview on 3/10/2020 at 9:42 a.m., with certified nursing assistant (CNA) G, CNA G stated the curtain should have been closed while he left to get Resident 14 a blanket. During an interview on 3/11/2020 at 9:10 a.m., the Director of Staff Development (DSD) stated, Resident 14 should not have been left with his incontinence brief and legs showing without privacy. During a review of the facility's policy and procedure, Quality of Life - Dignity, with a revised date of January 2011, indicated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care . .
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one out of 18 sampled residents (Resident 14), preferences for getting up out of bed were met. This failure resulted in the Resident spending most of his time in bed and in his room, alone. Findings: During an observation on 3/9/2020 at 10:30 a.m., Resident 14 was in his wheelchair in the dining room where activities assistant (AA) N was sitting down. The television was on and there were a total of 19 residents in the room, and one activities assistant. During a review on of Resident 14's clinical record, indicated Resident 14 had [DIAGNOSES REDACTED]. During a review of the most recent MDS (Minimum Data Set) assessment, a quarterly assessment dated [DATE], indicated Resident 14 was coded as needing extensive assistance of 2+ persons for bed mobility, personal hygiene, dressing and toilet use. Additionally, Resident 14 was coded for transferring (how the resident moves between surfaces to or from bed, chair, and wheelchair) as activity occurring once or twice with one person assistance in the past 7 day period. During a review of Resident 14's care plan, indicated Resident 14's ADL (activities of daily living) CARE PLAN with a start date of 6/23/19, did not have approaches specifying to get Resident 14 out of bed. The ADL care plan was updated on 3/10/2020 with a long term goal of, Will be able to participate in part of ADL activity .Approach Start Date: 3/10/2020 out of bed for 30 minutes before meals . During an interview on 3/10/2020 at 7:35 a.m., with certified nursing assistance (CNA) G, CNA G stated Resident 14 usually stayed in bed, unless his personal representative (PR) was in the facility. Additionally, CNA G stated Resident 14's PR needed to be with him because of his movements with his disease. When asked about Resident 14 observed in the dining room yesterday, CNA G stated Resident 14 was in his wheelchair yesterday because he was getting a new bed. Otherwise, he would have stayed in bed. During an interview on 3/10/2020 at 12:10 p.m., with Resident 14's PR, the PR stated she had spoken to the facility caregiving staff in the past to get the resident up more often. However, she stated staff had told her she needed to be present when he got up. During a review on 3/11/2020 at 3:55 p.m., of Resident 14's CNA documentation in the Point of Care History, from 2/11/2020 to 3/11/2020 for the area of, How did the resident transfer?, indicated Resident 14 was documented as transferred with extensive assistance on 2/15/2020 and 2/17/2020. During an interview on 3/11/2020 at 3:55 p.m., CNA H stated Resident 14 sometimes got up in the wheelchair when his PR visited. The CNA stated otherwise the facility did not get him up because of his [MEDICAL CONDITION]'s disease. During an interview on 3/10/2020, the Director of Staff Development (DSD) stated, the expectation was that Resident 14 would get up out of bed every day and should get up even if Resident 14's PR was not present. The DSD further stated it was a standard of care to get residents up. During a review of the facility's job description Certified Nurse Assistant (CNA) .ESSENTIAL JOB FUNCTIONS: .Provide care in a manner that protects and promotes resident rights, dignity, self-determination and active participation. Offer and respect resident choices in matters of daily routine. .
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on observation, interview, and record review, the facility failed to ensure care was provided according to professional nursing standards for one of 18 residents (Resident 31) when licensed vocational nurse E (LVN E) did not use the proper procedure for testing the blood sugar (a procedure performed by puncturing a person's finger with a lancet (a type of needle) to collect blood for testing sugar levels). This failure had the potential to affect the accuracy of blood testing and could cause harm to the resident. Findings: During a concurrent observation and interview on 3/10/2020 at 11:48 a.m., LVN E was observed checking the blood sugar for Resident 31. LVN E used the lancet to puncture the skin on Resident 31's finger, collected the first drop of blood, and placed an alcohol wipe at the puncture site. LVN E confirmed the first drop of blood was collected and an alcohol wipe was placed over the puncture site. During a review of the facility-provided Assure Platinum Blood Glucose Monitoring System: Quality Assurance/Quality Control (QA/QC) Reference Manual (undated), the manual did not indicate specific procedures for obtaining a blood sample for monitoring. During a review of the clinical guidance in Lexicomp (an online reference used by pharmacists, physicians, and nurses) titled, Skin Puncture Blood Collection, dated 2/27/18, the guidance indicated upon collection, the first drop (of blood) should be wiped away as it may be diluted by tissue fluid and after collection, apply direct pressure to the puncture site with sterile gauze until bleeding stops.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform initial pressure ulcer (damage to the skin or underlying tissue as a result of prolonged pressure) measurements and failed to provide pressure ulcer treatments for one of six sampled residents (Resident 183). These failures had the potential to cause worsening in Resident 183's pressure ulcers. Findings: Review of Resident 183's clinical record indicated he was admitted on [DATE] and had the [DIAGNOSES REDACTED]. Review of Resident 183's Compromised Skin Integrity document, dated 2/25/2020, indicated he had the following skin issues: 1. Open area on the left outer ankle that measured one by one centimeter (cm, unit of measurement) and had yellow slough (layer of dead tissue on a wound); 2. Open area on the left second toe with no specified measurements; and 3. Purplish discolorations on the left fourth toe with no specified measurements. Review of Resident 183's Skin Care Plan,

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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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) dated 2/25/2020, indicated to provide Treatments for wound care as ordered. Review of Resident 183's Physician order [REDACTED]. Starting 3/2/2020, Resident 183 had wound treatment orders for an unstageable pressure ulcer (pressure ulcer covered with slough or other tissue) on his left outer ankle, a deep tissue injury (DTI, pressure-related injury to tissues under intact skin) on his left second toe, and a DTI on his left fourth toe. Review of Resident 183's treatment administration record (TAR), indicated he did not receive treatments for the pressure ulcers on his left outer ankle, left second toe, and left fourth toe until 3/2/2020 (six days after the facility identified the pressure ulcers). During an interview and concurrent record review with the wound treatment nurse (WTN) on 3/11/2020 at 9:57 a.m., she confirmed that the nurse who completed the Compromised Skin Integrity document on 2/25/2020 did not include measurements for the pressure ulcers on Resident 183's left second toe and left fourth toe. She also confirmed there was no documentation of treatment for [REDACTED]. The WTN explained she was not working when the facility identified Resident 183's pressure ulcers on 2/25/2020. She further explained she initiated the measurements and treatments when she returned to work on 3/2/2020. The WTN stated the nurse who identified Resident 183's pressure ulcers should have done all measurements and initiated the treatments on 2/25/2020. Review of the facility's policy, Pressure Ulcer/Injury Risk Assessment, revised 7/2017, indicated The following information should be recorded in the resident's medical record utilizing facility forms: .2. The date and time and type of skin care provided, if appropriate .5. The condition of the resident's skin (i.e. the size and location of any red or tender areas), if identified.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate monitoring for safety for one of one sampled resident (Resident 12) when the alarm bracelet that was attached to the resident. This failure had the potential for the alarm system to not work and increased the risk for elopement. Findings: During a review of Resident 12's clinical record,it indicated Resident 12 had [DIAGNOSES REDACTED]. Further review, indicated Resident 12 had a Wander Guard alarm bracelet (a system that tracks the person using a wrist or ankle band and automatically alarms doors if the person moves outside a defined area), on her left ankle. During an observation on 3/9/2020 at 10:40 a.m., Resident 12 was observed in her wheelchair with an alarm band on her left ankle. Resident 12 was also observed wandering in her wheelchair, going into the nurse's station, and up and down the hall. During a review of the nursing progress note dated 2/13/2020 at 10:21 p.m., indicated Resident noted with restlessness, pacing along the hallway with her wheelchair. Noted with one episode of coming out of the facility up to the parking lot. Redirected and reoriented but still combative and agitated. Placed on 1:1 monitoring. Monitored every hour for safety and whereabouts . During a review of the care plan for the problem, ELOPEMENT CARE PLAN At risk for Elopement/Exiting Seeking .Goal .Will have reduced episodes of exiting the facility grounds .Approach .Check function and placement of wanderguard q (every) shift .Equip resident with a device that alarms when resident wanders. Check for proper functioning of device and alarms every shift. During a review of Resident 12's Physician order [REDACTED].Every shift; AM, PM, NOC (night). During an interview on 3/11/2020 at 11:00 a.m., with licensed vocational nurse (LVN) D, LVN D stated Resident 12 had never got out of the facility. LVN D further stated the Wander Guard system was checked by environmental services and stated the nurses did not check the Wander Guard system. When asked how the nurses knew the system was working, LVN D stated the alarm went off regularly at the door to the outside due to Resident 12's proximity to the doors. She stated there had been no elopements, only attempts by the resident to elope. During an interview on 3/11/2020 at 11:15 a.m., with the Director of Environmental Services (DES), the DES stated the environmental services department was responsible for checking the alarm at the 2 door that accessed outside, every morning. The DES further stated nursing staff were responsible to check the alarm bracelets on the residents. During an interview on 3/11/2020 at 11:20 a.m., with the Director of Staff Development (DSD), the DSD stated nursing staff were supposed to check the placement and function of the Wander Guard every shift, and stated the tester was in the nurses' cart. During an observation on 3/11/2020 at 11:21 a.m., of station 3 nurses' cart with the DSD and LVN D, indicated a tester was in the cart, but it was from the older system and did not work for the current Wander Guard system. During an interview on 3/11/2020 at 11:21 a.m., LVN D confirmed there was no tester for the current Wander Guard system in the nurses' cart. During an interview on 3/11/2020 at 2:45 p.m., with the director of nursing (DON), the DON stated the expectation was for the nurses to test the function of the Wander Guard bracelet attached to Resident 12, every shift. The DON confirmed the tester in the nurses' cart was not the correct one to test the bracelet. She stated she now had the correct tester, and would take it to the nurses so it could be put in the nurses' cart. During a review of the facility's policy and procedure, Assistive Devices and Equipment, with a revision date of July 2017, indicated Our facility provides, maintains, trains and supervises the use of assistive devices and equipment for residents .2. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the residents' plan of care. 3. Staff and volunteers will be trained and will demonstrate competency of the use of devices and equipment.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper placement of the gastrostomy tube ([DEVICE], a tube placed directly into the stomach through the abdomen that delivers food, fluids, and medications) for one of one resident (Resident 50). This failure had the potential to cause harm to the resident. Findings: During a concurrent observation and interview on 3/10/2020 at 9:24 a.m., with Licensed Vocational Nurse (LVN) F during medication administration, LVN F did not check Resident 50's [DEVICE] placement (a procedure used to ensure the [DEVICE] is positioned in the stomach) before flushing the [DEVICE] with water (the process of pouring water into the [DEVICE] to ensure the tube is clear of debris). LVN F stated she should have checked for placement. During a review of the facility's policy and procedure, Administering Medications through an Enteral Tube, dated 2017, the procedure indicated to confirm placement of feeding tube and check gastric residual volume (GRV) to assess for placement and tolerance of enteral feeding before flushing the [DEVICE] with water and administering medications.
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** Based on observation, interview, and record review, the facility failed to provide social services related to podiatry (the care and treatment of [REDACTED]. This failure had the potential to result in discomfort for the resident. Findings: During an observation on 3/9/2020, at 8:15 a.m., Resident 21 was observed to have long, thick toenails, with yellow and black discoloration on her right big toe toenail. During a concurrent interview and record review on 3/11/2020 at 10:15 a.m., with the wound treatment nurse (WTN), the current physician's orders [REDACTED]. The WTN stated podiatry was coordinated with social services. During a concurrent interview and record review on 3/11/2020, at 12:34 p.m., with the Director of Social Services (DSS), the Lumina Healthcare Podiatric Evaluation & Treatment Form, dated 9/26/2018, was reviewed. The form indicated Resident 21 was treated for [REDACTED]. The DSS confirmed the last podiatry consult was done in 2018 and stated the consult should have been done more recently. During a review of the facility's policy and procedure, Referrals, Social Services, dated December 2008, the policy indicated Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the accurate provision of pharmaceutical

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F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) services for one of two intravenous emergency kits (IV E-kit, a storage of emergency medications that are administered directly into the vein and supplies used to deliver the medications through the vein). This failure had the potential to result in the delay of treatment for [REDACTED]. The IV E-kit was last opened on 3/5/2020. During a concurrent interview and record review on 3/10/2020 at 8:53 a.m., in Med Room G with the DON, the IV E-kit Emergency Kit Dispensing Form, dated 3/5/20 was reviewed. The DON confirmed the form indicated the following items were taken out of the kit: one 24-gauge needle, one IV starter kit, and two extension max sets. During an interview on 3/10/2020, at 10:13 a.m. with the DON, she stated the IV E-kit should be replaced within 72 hours. During a review of the facility's policy and procedure, Emergency Medications, dated April 2007, it stated The facility shall maintain a supply of medication typically used in emergencies. Medications and supplies used from the emergency medication kit must be replaced upon the next routine drug order.
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** Based on interview and record review, the facility failed to monitor for [MEDICAL CONDITION] medication (medication capable of affecting the mind, emotions, and behavior) side effects and target behaviors (behavior intended to be changed by the medication) for one of five sampled residents (Resident 183). These failures had the potential to compromise the facility's ability to identify harmful effects from the medications and to monitor the effectiveness of the medications. Findings: Review of Resident 183's clinical record indicated he was admitted on [DATE] and had the [DIAGNOSES REDACTED]. Review of Resident 183's Physician order [REDACTED]. Resident 183 also had an order, dated 2/27/2020, for [MEDICATION NAME] (antidepressant which is often used to treat [MEDICAL CONDITION]) 50 mg by mouth at bedtime for [MEDICAL CONDITION]. Review of Resident 183's record indicated there was no documentation of monitoring for side effects of Ambien. There was also no documentation of monitoring for manifestations of [MEDICAL CONDITION]. During an interview and concurrent record review with the nurse case manager (NCM) on 3/11/2020 at 11:17 a.m., she stated the nurses should monitor for side effects and target behaviors of [MEDICAL CONDITION] medications every shift. The NCM stated this should be documented in the behavior monitoring section of the clinical record. The NCM explained that if a resident was taking [MEDICAL CONDITION] medication to treat [MEDICAL CONDITION], nurses should monitor the resident's number of sleep hours on the afternoon (PM) and night (NOC) shifts. The NCM reviewed Resident 183's clinical record and confirmed there was no documentation of monitoring for side effects of Ambien. She also confirmed there was no documentation of monitoring for number of sleep hours on the PM and NOC shifts. Review of the facility's policy, [MEDICAL CONDITION] Medication Use, revised 3/2018, indicated Monitoring of a resident receiving [MEDICAL CONDITION] medication will include evaluation of the effectiveness of the medication, as well as an assessment for possible adverse consequences. Behavioral symptoms are reevaluated periodically to determine the potential for reducing or discontinuing the drug based on therapeutic goals, and any adverse effects or possible functional impairment.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the safe and secure storage of medications in one of two medication rooms (Med Room H) and for one of four medication carts (Med Cart I) when: 1. For Med Room H, an expired vial of [MEDICATION NAME] (a medication classified as a [MEDICATION NAME] test used to test a person for [MEDICAL CONDITION] (an infection in the lung)) was stored in the medication refrigerator. 2. For Med Cart I, the cart was unlocked, with a drawer open, and medications were on top of the cart. These failures had the potential to result in harm to the residents. Findings: 1. During a concurrent observation and interview on [DATE] at 11:15 a.m., with licensed vocational nurse (LVN) D, the contents of medication room (Med Room) H were observed. The refrigerator in Med Room H contained a vial of [MEDICATION NAME] opened on [DATE] and another vial of [MEDICATION NAME] opened on [DATE]. LVN D stated the [MEDICATION NAME] is usually kept for 30 days after the date it was opened and the vials should be thrown out. During an interview on [DATE] at 12:38 p.m., with the Director of Staff Development (DSD), she confirmed [MEDICATION NAME] should only be stored for 30 days after opening. During a review of the clinical guidance in Lexicomp (an online drug reference used by pharmacists, physicians, and nurses) titled, [MEDICATION NAME] Tests: Storage/Stability, dated [DATE], the guidance indicated Opened vials should be discarded after 30 days. 2. During a concurrent observation and interview on [DATE] at 11:48 a.m., LVN E was observed passing medications for Resident 233 with her back toward the Med Cart I. Med Cart I was unlocked, had a drawer open, and had prescription eye drops on top. The DSD informed LVN E the medication cart should be locked. During an interview on [DATE] at 12:09 p.m. with the DSD, she confirmed Med Cart I should not have been opened during medication pass yesterday. During a review of the facility's policy and procedure, Security of Medication Cart, dated [DATE], the policy indicated The nurse must secure the medication cart during the medication pass to prevent unauthorized entry .Medication carts must be securely locked at all times when out of the nurse's view. During a review of the facility's policy and procedure, Administering Medications, dated [DATE], the policy indicated During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse .No medications are kept on top of the cart if unattended. During a review of the facility's policy and procedure, Storage of Medications, dated [DATE], the policy statement indicated The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the laboratory services as ordered by the physician for one of 18 sampled residents (Resident 8). This failure had the potential for the resident not to be adequately monitored for changes in condition in order to provide necessary treatment. Findings: Review of Resident 8's Admission Record indicated she had [DIAGNOSES REDACTED]. During an interview with the nurse case manager (NCM) on 3/11/2020 at 10:20 a.m., she reviewed the physician order [REDACTED]. She stated her initials and the word noted, dated 9/16/19, written below the physician's orders [REDACTED]. The NCM further stated carrying out the order would include entering the order into the computer and completing a laboratory requisition form for the bloodwork that was ordered. The NCM reviewed Resident 8's clinical record and the laboratory requisition binder and confirmed there was no laboratory results of any HgA1C being done after 9/16/19, when the physician ordered to check Resident 8's HgA1C in two months. During an interview with the director of nursing (DON) on 3/11/2020 at 10:30 a.m., she reviewed Resident 8's clinical record and was unable to locate any laboratory results for a HgA1C done after 9/16/19, when the physician ordered to check the HgA1C. She confirmed the laboratory test should have been completed as ordered by the physician. Review of the facility's policy dated 6/2013, Physician Orders, indicated physician orders [REDACTED]. Review of the facility's policy dated 4/2007, Request for Diagnostic Services, indicated orders for diagnostic services will be promptly carried out as instructed by the physician's orders [REDACTED].
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and document review, the facility failed to ensure food was prepared and served under sanitary conditions when: 1. Cook A used incorrect technique when testing the kitchen sanitizer solution (solution used to

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) disinfect food contact surfaces in the kitchen); and 2. Staff did not completely cover their hair with hair nets in the food preparation area of the kitchen. These failures had the potential to cause food contamination and spread foodborne illness (illness resulting from contaminated food) to residents who received their food from the kitchen (80 of 83 residents). Findings: 1. During an observation on 3/9/2020 at 8:20 a.m., Cook A tested the kitchen sanitizer solution, which was contained in a red bucket at the food preparation sink. Cook A took a piece of test paper, dipped it in the solution for approximately one second, then checked to see if the test paper changed to the appropriate color. Cook A used a thermometer to check the temperature of the kitchen sanitizer solution. The reading on the thermometer indicated the solution had a temperature of 157 degrees Fahrenheit (F, unit of temperature measurement). Review of the instructions printed on the test paper packaging indicated to dip the paper in the solution for ten seconds. The instructions also indicated the solution should be between 65-75 degrees F. During an interview with Cook A on 3/9/2020 at 8:22 a.m., he reviewed the test paper instructions and acknowledged he was supposed to dip the test paper in the solution for ten seconds. He also acknowledged the solution was supposed to be between 65-75 degrees F. Cook A stated the solution was too hot. 2. During an observation on 3/10/2020 at 10:30 a.m., Cook A prepared pureed (blended into a thick sauce-like texture) food to be served for lunch. Several times during the procedure, Cook A stopped the blender, took off the lid, and looked into the blender with his head directly above it. The hair on the sides and on the back of Cook A's hair was not covered by his hair net. During an observation on 3/10/2020 at 10:40 a.m., the registered dietician (RD) walked around the food preparation area of the kitchen doing multiple tasks, including handling food items that she took out of the refrigerator. The hair on the sides and on the back of the RD's head were not covered by her hair net. During an observation on 3/10/2020 at 11:40 a.m., Cook A handled food at the steam table (table that keeps food hot). He took the foil covering off the metal food containers and checked the food temperatures. Several times during this process, Cook A's head was directly above the uncovered food. After taking the food temperatures, Cook A began putting the food items on plates. The hair on the sides and on the back of Cook A's head was not covered by his hair net. During an observation on 3/10/2020 at 11:45 a.m., the administrator (ADM) helped kitchen staff with tray line (system of food preparation, used in hospitals, in which trays move along an assembly line). The ADM was handling uncovered plates of food and putting lids on them. The hair on the sides and on the back of the ADM's head was not covered by her hair net. During an observation and concurrent interview with the dietary consultant (DC) on 3/10/2020 at 11:52 a.m., he acknowledged Cook A and the ADM did not have their hair fully covered while handling food. The DC confirmed their hair should have been completely covered by their hair nets. Review of the facility's policy, Food Preparation and Service, revised 10/2017, indicated Food and nutrition services staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. The U.S. Food & Drug Administration Food Code, dated 2017, indicated food employees shall wear hair restraints that are designed and worn to effectively keep their hair from contacting exposed food.
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** Based on observation, interview, and record review the facility failed to ensure infection control practices were followed when the following were identified: 1. Droplet precautions were not followed for two (Residents 50 and 284) out of two sampled residents that were coughing. 2. A urinary catheter drainage bag was placed above the bladder for one (Resident 284), out of two sampled residents reviewed for urinary catheters. 3. A blood pressure cuff was not cleaned after use. 4. Hand hygiene was not performed after administration of a medication. These failures had the potential to cause infection in a vulnerable population. Findings: 1. During a review of Resident 50's clinical record, indicated, Resident 50 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Further review of the record indicated Resident 50 had a gastrostomy tube ([DEVICE], a tube placed directly into the stomach through the abdomen that delivers food, fluids, and medications). During an observation on 3/10/2020 at 9:24 a.m., licensed vocational nurse (LVN) F was observed administration medications via Resident 50's gastrostomy tube without wearing a face mask. Resident 50 was coughing. During an interview on 3/10/2020 at 9:24 a.m., LVN F stated she did not need a mask because Resident 50 had a negative chest X-ray (a test that provides images used to identify abnormal structures in the chest, including the lungs) last week. During a review of Resident 284's clinical record, indicated Resident 284 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. flow in the lungs); [MEDICAL CONDITION] (an enlarged prostate gland that can cause blocking of the flow of urine) and retention of urine (the inability to voluntarily void urine). During a review of Resident 284's care plan, indicated Resident 284's was care planned for the problem Resident has potential for complications related to pneumonia .Approach .Follow principles of infection control and universal/standard precautions. During an observation on 3/9/2020 at 11:00 a.m., Resident 284 was observed in bed, coughing. During a subsequent observation on 3/10/2020 at 11:15 a.m., certified nursing assistants (CNA) K was assisting Resident 284 in bed with peri-care (perineal care, cleaning the private areas of a resident) and repositioning. During the observation Resident 284 was coughing. CNA K did not wear a face mask. During an observation on 3/10/2020 at 2:40 p.m., physical therapist assistant (PTA) L and occupational therapist (OT) M were observed standing next to Resident 284 in his room as they assisted him to stand using an APEX frame (a standing frame that helps to support physically challenged individuals with mild to severe disabilities). During the observation, Resident 284 was coughing. PTA L and OT M were not wearing face masks. During the same observation, CNA K, entered the resident's room and assisted the PTA and OT to transfer Resident 284 to bed to assist with peri-care. The CNA K did not wear a face mask. During an interview on 3/11/2020 at 8:05 a.m. with CNA K, CNA K stated she had cared for Resident 284 for the past 4 days. CNA K further stated she did not know until today that she should wear a face mask while providing care to Resident 284. During an interview on 3/11/2020 at 8:10 a.m., with registered nurse (RN) O, RN O stated she was Resident 284's nurse today. RN O stated staff should wear a face mask when providing care to Resident 284 for droplet precautions. During an interview on 3/11/2020 at 9:00 a.m., with the Director of Rehabilitation (DR), the DR stated she had just received a notice and in-service this morning that staff should wear a mask while providing care for Resident 284. During an interview on 3/11/2020 at 7:45 a.m., with the Infection Control Nurse (ICN), the ICN stated any residents with a cough were being monitored for respiratory concerns. The ICN stated Residents 50 and 284 were currently monitored. The ICN stated the expectation was for staff to wear face masks with cares for any residents with a cough. During a review of the facility's policy and procedure, Standard Precautions, with a revision date of October 2018, indicated Standard Precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all .secretions .may contain transmissible infectious agents . Further review the facility's policy and procedure, Standard Precautions, indicated the policy had an attachment entitled Transmission-Based Precautions, with a revision date of August 2016. The document stated, Droplet Precautions Potential exposure to microorganisms through droplets, via cough, sneeze, etc .Wear masks or face shield if you come within 3 feet of the resident. 2. During a review of Resident 284's care plan, indicated Resident 284's was care planned for the problem INDWELLING URINARY CATH (catheter) CARE PLAN .Approach .Place bag below bladder . During an observation on 3/10/2020 at 2:40 p.m., PTA L and OT M were observed assisting Resident 284 to stand using an APEX (standing) frame. Resident 284 was sitting and holding onto the handle bars (at chest height). Further observation of Resident 284's urinary catheter drainage bag (a bag connected to a tube that was inserted through the urinary tract into the bladder), indicated, the bag was hanging from the handle bars of the APEX frame which was above the Resident's bladder. During an interview on 3/10/2020 at 2:42 p.m., when asked about where the placement of the urinary catheter drainage bag should be placed, the PTA L stated she was not sure where the bag should be hung. During an interview on 3/10/2020 at 2:43 p.m., CNA K, who had just entered the Resident 284's room, stated the urinary catheter drainage bad should not be above the bladder and proceeded to move the bag. The CNA attached the bag to the Resident's wheelchair that was below the bladder. During an interview on 3/12/2020 at 12:45 p.m., the ICN stated the expectation was to keep the urinary catheter drainage bag below the bladder when transferring the resident and to ensure it was kept below the bladder when he was sitting. The INC stated she gave an in-service to the therapy department on this. During a review of the facility's policy and procedure, Indwelling Urinary Catheter, undated, indicated The purpose of this procedure is to prevent catheter-associated urinary tract infections by maintaining unobstructed urine flow .The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. 3. During an observation on 3/9/2020 at 9:08 a.m., LVN B was observed using the blood pressure cuff attached to a vital signs machine (a reusable machine that is used to measure a person's pulse and blood pressure) to take Resident 11's blood pressure without disinfecting the blood pressure cuff before or after use. During an interview on 3/9/2020 at 9:25 a.m., LVN B stated the blood pressure cuff on the vital signs machine is used for multiple residents and should be cleaned before using it on the resident. During a review of the facility's policy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555792	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) Cleaning and Disinfection of Resident-Care Items and Equipment, dated July 2014, the policy indicated reusable items are cleaned and disinfected between residents. 4. During a concurrent observation and interview on 3/9/2020 at 10:34 a.m., LVN D was observed administering eye drops to Resident 24. After the procedure, LVN D removed her gloves and did not perform hand hygiene before touching the medication cart and computer. LVN D confirmed she should have cleaned her hands before touching the cart and computer. During a review of the facility's policy, Standard Precautions, dated October 2018, the policy indicated after gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments.