STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055737	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Hills Post Acute	12200 LA Mirada Blvd. LA Mirada, CA 90638

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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F 0684 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 assess and treat one of two sampled residents (Resident 1) after being exposed to scabies (a highly contagious skin infection caused by the microscopic mite), by failing to ensure staff: 1. Performed a skin assessment and tested Resident 1 for scabies after Resident 1's roommate tested positive for scabies. 2. Treated Resident 1 for scabies. These deficient practices resulted in Resident 1 expressing feelings of discomfort from constant itchiness and scratching and had the increased risk of scabies transmission to residents and staff. Findings:1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and anxiety disorder (intense, excessive and persistent worry and fear about everyday situations). During a review of Resident 1's History and Physical (H&P) dated 8/29/2025, the H&P indicated Resident 1 did not have the mental capacity to make decisions. During a review of Resident 1's Minimum Data Set ([MDS] a resident assessment tool), dated 8/13/2025, the MDS indicated Resident 1's cognitive skills for daily decision making was impaired (ability to think and reason). The MDS indicated Resident 1 required set up assistance for eating, oral hygiene and personal hygiene. The MDS indicated Resident 1 required supervision for toileting hygiene and dressing. The MDS indicated Resident 1 required maximal assistance (helper does more than half the effort) for shower/bathing. During a review of Resident 1's electronic medical record, unable to locate Resident 1's skin assessment. During a concurrent observation and interview on 9/9/2025 at 12:37 p.m. with Resident 1, in Resident 1's room, Resident 1 was observed with a red rash on the right shoulder. Resident 1 stated she had been itching for weeks and informed staff. Resident 1 stated she had scabies before and knew the rash she currently had was also scabies. Resident 1 stated staff did not assess her skin or address her itchiness. Resident 1 stated she had a rash on both of her legs as well. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnoses included diabetes and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing) During a review of Resident 2's History and Physical (H&P) dated 8/31/2025, the H&P indicated Resident 2 had the mental capacity to make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 required supervision for eating, oral hygiene and personal hygiene. The MDS indicated Resident 2 required maximal assistance for toileting hygiene and shower/bathing. During an interview on 9/9/2025 at 12:13 p.m. with Resident 2, in Resident 2's room, Resident 2 stated a couple of days prior, she overheard Resident 1 say she had scabies. Resident 2 stated yesterday (9/8/2025) she observed Resident 1 scratching herself. During an interview on 9/11/2025 at 9:46 a.m. with Treatment Nurse (TN) 1, TN 1 stated he did not routinely assess Resident 1's skin because the resident did not have any known skin issues. TN 1 stated he was not notified of Resident 1's rash. TN 1 stated he was supposed to know of every resident's skin issues. TN 1 stated monitoring of Resident 1's skin should have been started after the facility was informed of the resident's roommates' positive scabies results. TN 1 stated it was beneficial to report skin issues for early detection and to start treatment. During an interview on 9/11/2025 at 11:10 a.m. with the Infection Preventionist Nurse (IPN), the IPN stated she was informed Resident 1's previous roommate tested positive for scabies over a week ago. The IPN stated she did not assess Resident 1 after she found out her roommate tested positive. The IPN stated Resident 1 needed to be placed in isolation and tested for scabies because she was exposed. The IPN stated she did not test Resident 1 or place Resident 1 on isolation. The IPN stated not placing exposed residents in isolation increased the risk of spreading scabies. During an interview on 9/11/2025 at 2:17 p.m. with the Director of Nursing (DON), the DON stated all residents exposed to scabies had to be placed in isolation and tested for scabies. The DON stated licensed nurses should have assessed Resident 1after finding out her roommate was positive for scabies. The DON stated it was important to assess residents to prevent the spread of scabies and for early plan of care. During a review of the facility's Policy and Procedure (P&P) titled Head Lice and Scabies Exposure and Treatment, dated 12/19/2022, the P&P indicated it was the facility's policy to ensure that residents who contract scabies or head lice are treated according to current standards of practice to eradicate the infestation and prevent further exposure and transmission. The P&P indicated residents who may have had potential contact with