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	02/17/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician and Responsible Party (RP) of a change of condition (COC) for one of five sampled residents (Resident 1), who had a [NAME] Blood Cell ([WBC]-part of the body's immune system that protects the body from infection) count of 15,200 (normal reference range 4,000-10,000 cells per microliter [cells/?L]).This deficient practice had the potential to result in Resident 1 not receiving necessary medical care and placed the resident at risk of sepsis (a life?threatening blood infection). Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and re admitted on [DATE]. The admission Record indicated Resident 1's diagnoses included mild protein -calorie malnutrition (the body receives insufficient protein and calories, leading to subtle loss of muscle and fat) and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 1's History and Physical (H&P) dated, 12/3/2025 the H&P indicated Resident 1 did not have the capacity to make medical decisions. During a review of Residents 1's Minimum Data Set (MDS - a resident assessment tool) dated 12/4/2025, the MDS indicated Resident 1 had severe cognitive (ability to think and reason) impairment. The MDS indicated Resident 1 was dependent on staff for activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During a review of Resident 1's Physicians Orders dated, 12/15/2025 the physician's orders indicated to obtain STAT (urgent) laboratory (lab) tests (analyzing samples of blood or urine to diagnose disease, monitor health condition and plan treatment) including a complete blood count (CBC), comprehensive metabolic panel (CMP) and urine for culture and sensitivity laboratory. During a review of Resident 1's Lab Results Report collection date 12/15/2025 at 11:04 a.m. and report date of 12/15/2025 at 2:23 p.m., the Report indicated Resident 1's WBC count was 15,200 cells/?L. During a review of Situation Background Assessment Recommendation (SBAR) communication form on 12/15/2025. The SBAR indicated the physician and family were informed of Resident 1's weight loss. The SBAR did not indicate the physician and Resident 1's RP were notified of Resident 1's elevated WBC count. During a concurrent interview and record review on 2/17/2026 at 2:20 p.m., with Licensed Vocation Nurse (LVN) 2, Resident 1's Lab Results Report dated 12/15/2025 was reviewed. LVN 2 stated Resident 1 had an elevated WBC count and there was no COC completed. LVN 2 stated, the physician, and RP should have been notified of this COC (on 12/15/2025). LVN 2 stated an elevated WBC could be a sign of sepsis. During an interview on 2/17/2026 at 4:00 p.m., with Registered Nurse (RN) 1, RN 1 stated any abnormal lab results should be reported to the physician and documented as a COC. RN 1 stated it was important to notify the physician and the RP of any change in Resident 1's health. RN 1 stated Resident 1 had a change from his baseline lab (prior WBC count) and a COC should have been completed (on 12/15/2025). During an interview on 2/17/2026 at 4:10 p.m., with the Director of Nursing (DON), the DON stated nurses must completed a COC if a resident's lab was abnormal. The (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

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 02/17/2026

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses would describe the condition of the COC and doctors' orders. The DON stated it was important to complete a COC and notify the physician and RP so everybody would be aware of the resident's abnormal labs. During a review of the facility's Policies and procedure (P&P) titled, Notice of Changes, dated 12/19/2022 the P&P indicated the facility must inform the resident's physician and /or notify the residents family member or legal representative when there is a changed requiring such notification included significant change in resident's physical, mental, or psychological conditions such as deterioration in health, mental or psychosocial status

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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 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 observation, interview and record review, the facility failed to ensure proper infection control practices were followed during wound care for one of five sampled residents (Resident 2), who was admitted to the facility with a stage 4 pressure injury (full-thickness loss of skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the sacrococcygeal region (consists of the sacrum and coccyx [tailbone]). This deficient practice placed Resident 2 at risk for poor wound healing, infection, and deterioration of the resident's existing pressure injury. Findings: During a concurrent wound care observation and interview on 2/13/2026 at 9:10 a.m., in Resident 2's room with LVN 1, Resident 2 was observed turned to side and had a soiled brief, containing a small amount of brown feces. LVN 1 was observed removing Resident 2's old wound dressing and cleansed the wound with wet gauze soaked in normal saline (NS- a saltwater solution). LVN 1 completed Resident 2's wound care, then proceeded to place the soiled brief back on the resident. LVN 1 stated the brief was dirty with stool, but she would wait for the Certified Nursing Assistant (CNA) to change it later. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including osteomyelitis (severe bone infection) of the vertebra, sacral and sacrococcygeal region, pressure injury of sacral region stage 4, and hypertension (HTN-high blood pressure). During a review of Resident 2's Care Plan titled, Resident.admitted with Pressure injury (ulcer) stage 4 to sacrococcygeal area, chronic dated 11/28/2025, The Care Plan indicated to keep skin clean and provide skin care per facility guidelines. During a review of Resident 2's History and Physical (H&P) dated 12/5/2025, the H&P indicated Resident 2 had the capacity to make decisions. During a review of Residents 2's Minimum Data Set (MDS - a resident assessment tool) dated 12/4/2025, the MDS indicated Resident 2's had no cognitive (ability to think and reason) impairment. The MDS indicated Resident 2 was dependent on staff for activities of daily living (ADLs) such as dressing, toilet use, personal hygiene, transfer and mobility. During a review of Resident 2's Physicians Order dated, 2/11/2026, the Order indicated to cleanse Resident 2's Stage 4 pressure injury with NS, pat dry, apply think layer of house moisture barrier cream to periwound (area of tissue immediately surrounding a wound) followed by medihoney gel (solution for wound healing and skin protectant) to the wound bed. Top with Calcium Alginate (foam that promotes wound healing) cut to fit and cover with super absorbent bordered foam dressing daily and as needed. During an interview on 2/17/2026 at 12:40 p.m., with LVN 1, LVN 1 stated (during Resident 2's wound care on 2/13/2026 at 9:10 a.m.) she should have changed Resident 2's incontinence brief first and ensured the resident was clean before proceeding with the dressing change. LVN 1 stated it was important to do this because if the wound was exposed to feces, it could cause contamination (transfer of harmful bacteria from one place to another) and placed the resident at risk for infection. During an interview on 2/17/2026 at 4:00 p.m., with Registered Nurse (RN) 1, RN 1 stated nurses should clean residents first (from stool and urine) before completing a wound care and dressing change. RN 1 stated this process was followed to prevent infection (of the resident's pressure injury). RN 1 stated exposing a resident's pressure injury to feces or urine could lead to worsening of the wound, a delay in healing of the wound and placed the resident at increased risk for infection and sepsis (a life-threatening blood infection). During an interview on 2/17/2026 at 4:10 p.m., with the Director of Nursing (DON), the DON stated LVN 1 should have ensured Resident 2 was cleaned (from having a bowel movement) and that a clean incontinence brief was placed on the resident and wound instead of a soiled one. The DON stated it was important to keep Resident 2's wound clean and dry to prevent wound infection. During a review of the facility's Policies and procedure (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(P&P) titled, Pressure Injury Prevention and Management dated 9/12/2023, the P&P indicated the facility is committed to the provide treatment and services to heal pressure injury and prevent infection. Evidence-based intervention for prevention (and to promote wound healing) included to minimize exposure to moisture and keep skin clean, especially of fecal contamination.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper nutritional assistance for one of five sampled residents (Resident 5), who is at risk for malnutrition (which occurs when a person receives too few nutrients, resulting in health problems). The facility failed to:Assist Resident 5 with eating as indicated in the resident's nutritional problem/potential nutritional problem care plan.Ensure timely meal support, as Resident 5's food tray was left open in front of the resident for 20 minutes before the resident assisted eating.These deficient practices placed Resident 5 at risk for weight loss and potential hospitalization related to malnutrition.Findings:During a concurrent observation and interview on 2/13/2026 at 12:29 p.m., in Resident 5's room, Resident 5 was observed in a high?Fowler's position (head of the bed elevated between 60 and 90 degrees) with a white towel around his chest area and an open meal tray was on the bedside table in front of the Resident. Resident 5 opened his eyes and nodded when asked if he wanted to eat. Resident 5 stated, Yes, I need help eating. The food tray remained open with no Certified Nursing Assistant (CNA) present in the room to assist the resident.At 12:45 p.m., (16 minutes later) CNA 1 entered Resident 5's room and stated Resident 5 was not part of her assignment but she could assist the resident with eating. CNA 1 fed the resident one spoonful of food and then left the room to get water.At 12:51 p.m., CNA 1 returned and resumed feeding Resident 5. CNA 1 stated that Resident 5 required one?to?one (1:1) feeding assistance (dedicated staff member assigned to assist a single resident with eating and drinking during mealtimes) with meals. CNA 1 also stated that if a food tray was left open for a long time without the Resident being fed, the food can get cold. CNA 1 stated it was not acceptable to feed residents cold food and added that Resident 5 could be at risk for weight loss if the resident was not assisted with eating timely.During a review of Resident 1's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 5's diagnoses included anemia (a condition where the body does not have enough healthy red blood cells), muscle weakness and dysphagia, oropharyngeal phase (is a disorder that causes difficulty with swallowing).During a review of Resident 5's History and Physical (H&P) dated 12/20/2025, the H&P indicated Resident 5 had the capacity to understand to make decisions.During a review of Residents 5's Minimum Data Set (MDS - a resident assessment tool) dated 12/2/2025, the MDS indicated Resident 5 had severe cognitive (ability to think and reason) impairment. The MDS indicated Resident 5 was dependent on staff for activities of daily living (ADLs) such as dressing, toilet use, transfer and mobility. The MDS indicated Resident 5 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating.During a review of Resident 5's Physicians Orders dated 3/6/2025 the physician's orders indicated Resident 5 was a 1:1 Feeder.During a review of Resident 5's Nutritional Care Plan dated 12/15/2025, the Care Plan indicated Resident 5 had nutritional problem or potential nutritional problem.The Care Plan interventions indicated to provide and serve diet as ordered and provide 1:1 feeding assistance.During a review of Resident 5's Nutritional assessment dated [DATE]. The Nutritional Assessment indicated dietary interventions for Resident 5 included to provide 1:1 feeding assistance. During an interview on 2/17/2026 at 10:40 a.m., with CNA 3, CNA 3 stated licensed nurses would inform the CNAs which residents required feeding assistance. CNA 3 stated when food trays arrived, they first passed trays to other residents and lasty, would take trays to residents who required 1:1 feeding and begin assisting them. CNA 3 stated on 2/13/2026 at 12:29 p.m., she was assigned to Resident 5. Resident 5 usually ate slowly and needed 1:1 assistance with eating. CNA 3 stated she went to place a towel on (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5 and opened his meal tray in front of the resident. Resident 5 opened his eyes, left the tray on the table and left the room to pass out meal trays to other residents. CNA 3 stated she planned to return 10 minutes later to assist the resident with eating. CNA 3 stated did not check on him afterward and did not return to see whether he was eating. CNA 3 stated that if the tray was left open, the food could get cold and this could affect Resident 5's health. CNA 3 stated it was not acceptable to leave a tray unattended for 20 minutes in front of the resident, as he may feel bad being unable to eat by himself.During an interview on 2/17/2026 at 4:00 p.m., with Registered Nurse (RN) 1, RN 1 stated upon a resident's admission to the facility, the dietitian assesses whether the resident needs assistance with eating. RN 1 stated that feeder 1:1 means the resident required one staff member to assist with eating. RN 1 stated the food tray should not be left in front of a resident without assistance. RN 1 explained that the food could become cold and unappetizing. RN 1 stated that Resident 5 may feel discouraged and frustrated when food is placed in front of him without assistance, and that eating cold food puts him at risk for an upset stomach or becoming ill.During an interview on 2/17/2026 at 4:10 p.m., with the Director of Nursing (DON), the DON stated CNAs should pass trays and then deliver the tray to the resident who requires one?to?one feeding, ensuring the tray was not left open, as the food could become cold. The DON stated CNAs need to ensure the residents were being assisted with eating. During a review of the facility's Policies and procedure (P&P) titled, Meal Supervision and Assistance, dated 12/19/2022 the P&P indicated, Compliances guidelines: Assemble equipment and supplies needed. Do not serve the meal until the attendant is ready to assist the resident.