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	05/28/2026

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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(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 one of three sampled residents' (Resident 1) primary care physician (PCP), when the resident did not receive prescribed Buprenorphine (a controlled [regulated] pain medication for the management of severe, persistent, and chronic pain) and Ozempic (medication to lower blood sugar).This failure placed the resident at risk for potential complications such as increased need of pain medication, poor pain management, and complications from diabetes such as diabetic ketoacidosis (a life-threatening complication that can occur if blood glucose levels are high) leading to hospitalization.Findings: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 unspecified (unknown) fracture (broken bone) of sacrum (tailbone), subsequent encounter (follow-up or routine aftercare) for fracture with routine healing. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated, 4/2/2026, the MDS indicated Resident 1 had moderate cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) for Activities of Daily Living (ADLs) such personal hygiene and required substantial/maximal assistance (helper does more than half the effort) for ADLs such as showering/bathing self. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform movements such as rolling left and right and transferring from bed to chair. During a review of Resident 1's Order Summary report, dated 3/27/2026, the Order Summary Report indicated, Buprenorphine Transdermal (through the skin) Patch Weekly 7.5 micrograms ([mcg], unit of weight in the metric system equal to one-millionth of a gram)/hour (hr.), apply 1 patch transdermal every Monday (Mon) for pain, change patch every week. The start date was dated 4/1/2026. During a review of Resident 1's Medication Administration Record (MAR), for the month of 4/2026, the MAR indicated Resident 1 did not receive the prescribed Buprenorphine medication on 4/8/2026 and 4/15/2026 and Ozempic on 4/6/2026, 4/13/2026, 4/20/2026, and 4/27/2026. During a review of Resident 1's Nursing progress notes, dated 4/8/2026 to 4/27/2026, the progress notes indicated, meds on order. The progress notes did not indicate Resident 1's PCP was notified about the missed doses of Buprenorphine medication on 4/8/2026 and 4/15/2026, and Ozempic on 4/6/2026, 4/13/2026, 4/20/2026, and 4/27/2026. During a concurrent interview and record review on 5/27/2026 at 2:33 p.m., with Licensed Vocational Nurse (LVN) 1, the following were reviewed:Resident 1's MAR for Buprenorphine, for the month of 4/2026.Resident 1's MAR for Ozempic, for the month of 4/2026.Resident 1's Progress notes, dated 4/6/2026, 4/8/2026, 4/13/2026, 4/15/2026, 4/20/2026, and 4/27/2026.LVN 1 stated that on 4/8/2026 and 4/15/2026, the MAR did not indicate that Resident 1 received the Buprenorphine medicine, and the Ozempic on 4/6/2026, 4/13/2026, 4/20/2026, and 4/27/2026. During interview on 5/27/2026 at 4:35 p.m., with the Director of Nursing (DON), the DON stated if the Buprenorphine and Ozempic were not given, Resident 1's blood sugar and pain could not be managed effectively. During an interview on 6/1/2026 at 2:18 p.m., with the DON, the DON stated Resident 1's progress notes did not indicate that the PCP (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was notified about the missed doses of Buprenorphine and Ozempic. During a review of facility's policy and procedure (P&P) titled, Notification of Changes, dated 12/19/2022, the P&P indicated, the facility must consult with the resident's physician when there is a change requiring notification. The P&P indicated. circumstance requiring notification include circumstances that require a need to alter treatment.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents' (Resident 1), pain level was reassessed timely, after the pain medication was administered.This failure placed Resident 1's pain level unresolved and the potential to affect in maintaining the resident's highest practicable physical, mental and psychosocial wellbeing.Findings: 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 unspecified (unknown) fracture (broken bone) of sacrum (tailbone), subsequent encounter (follow-up or routine aftercare) for fracture with routine healing. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated, 4/2/2026, the MDS indicated Resident 1 had moderate cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) for Activities of Daily Living (ADLs) such personal hygiene and required substantial/maximal assistance (helper does more than half the effort) for ADLs such as showering/bathing self. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform movements such as rolling left and right and transferring from bed to chair. During a review of Resident 1's Order Summary report, Resident 1's physician's order, dated 3/30/2026, indicated, Hydromorphone (also known as Dilaudid, a powerful, prescription-only pain medication used to treat severe pain) 4 milligrams ([mg], metric unit of measurement) one tablet by mouth every four (4) hours, as needed (PRN) for (7/10) severe pain (a numerical pain scale used in a facility with 0 no pain, 1-3 mild pain, 4-6 moderate pain, 7-8 severe pain, 9-10 worst pain possible) and Hydrochloric Acid (HCl) Oral Tablet 4 mg, 1 tablet by mouth every 4 hours PRN for 7-10 pain. During a review of Resident 1's Medication Administration Record (MAR), for the month of 4/2026, the MAR indicated that on 4/8/2026 at 8:49 p.m., Resident 1 received Hydromorphone HCl 4 mg tablet for 9/10 (severe pain) pain level and 10/10 (severe pain) on 4/10/2026 at 7:52 p.m. During a review of Resident 1's progress notes dated 4/8/2026 at 10:18 p.m., the progress notes indicated Resident 1's pain level was reassessed, and the level was 2/10 (mild pain). The progress notes dated 4/10/2026 at 11:27 p.m., indicated Resident 1's pain level was reassessed, and the level was 1/10 (mild pain). During a concurrent interview and record review on 5/27/2026 at 4:03 p.m., with Licensed Vocational Nurse (LVN) 3, Resident 1's MAR, dated 4/8/2026 and 4/10/2026, and progress notes dated 4/8/2026 and 4/10/2026 were reviewed. LVN 3 stated after the pain medications were administered to Resident 1 on 4/8/2026 and 4/10/2026, the facility staff should have reassessed the resident's pain level after an hour, to determine if the resident's pain has improved or not. LVN 3 stated Resident 1's progress notes indicated that on 4/8/2026 and 4/10/2026, Resident 1's pain level was reassessed more than an hour after the pain medication was administered. LVN 3 stated it was important to reassess the resident's pain level and document the reassessment to ensure that the resident's pain was managed timely. During an interview on 6/1/2026 at 2:18 p.m., with the Director of Nursing (DON), the DON stated it was not acceptable to reassess Resident 1's pain level more than one hour after the pain medications were administered as the resident's pain level could have been unmanaged. During a review of facility's policy and procedure (P&P) titled, Pain Management, dated 3/17/2025, the P&P indicated, the facility must ensure that pain management is provided to residents in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences.

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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 interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), medications was available, and were administered to the resident, and, ensure the medication brought to the facility by a family member (FM) was verified, order obtained to administer, according to its policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy. These failures placed Resident 1 at risk for complications when medications were received or not received as ordered, which could lead to hospitalizations.Findings: 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 unspecified (unknown) fracture (broken bone) of sacrum (tailbone), subsequent encounter (follow-up or routine aftercare) for fracture with routine healing. During a review of Resident 1's Order Summary report dated 3/27/2026, the order summary report indicated to apply Buprenorphine Transdermal (through the skin) Patch (a controlled [regulated] pain medication for the management of severe, persistent, and chronic pain) weekly 7.5 micrograms ([mcg], unit of weight in the metric system equal to one-millionth of a gram)/hour (hr), 1 patch transdermal every Monday (Mon) for pain and change patch every week, start date of 4/1/2026. The Order Summary Report dated 3/26/2026, indicated to inject Ozempic 0.5 milligrams (mg., a unit of measurement) subcutaneously (under the skin) weekly, every Monday for diabetes (abnormal blood sugar levels) management. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool) dated, 4/2/2026, the MDS indicated Resident 1 had moderate cognitive impairment (problems with the ability to think, remember, and solve problems). The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) for Activities of Daily Living (ADLs) such personal hygiene and required substantial/maximal assistance (helper does more than half the effort) for ADLs such as showering/bathing self. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) to perform movements such as rolling left and right and transferring from bed to chair. During a review of Resident 1's Medication Administration Record (MAR), for the month of 4/2026, the MAR did not indicate Resident 1 received the Buprenorphine Transdermal Patch on 4/8/2026 and 4/15/2026. The MAR did not indicate Resident 1 received Ozempic on 4/6/2026, 4/13/2026, 4/20/2026, and 4/27/2026. During a review of Resident 1's Progress Notes, dated 4/6/2026, 4/8/2026, 4/13/2026, 4/15/2026, 4/20/2026, and 4/27/2026, the progress notes indicated Resident 1 did not receive the prescribed Ozempic and the Buprenorphine Transdermal Patch because the medications were on order. During a concurrent interview and record review on 5/27/2026 at 2:23 p.m., with the Licensed Vocational Nurse (LVN) 1, Resident 1's MAR, for the month of 4/2026, and the progress notes, dated 4/6/2026, 4/8/2026, 4/13/2026, 4/15/2026, 4/20/2026, and 4/27/2026, were reviewed. LVN 1 stated the MAR did not indicate Resident 1 received the Buprenorphine patch on 4/8/2026 and 4/15/2026 because the medications were on order. LVN 1 stated it placed Resident 1 at risk for pain. LVN 1 stated staff should have followed up the ordered missing medications from the pharmacy. LVN 1 stated Resident 1's progress notes did not indicate what further actions were done when Resident 1 did not receive Ozempic medications on 4/6/2026, 4/13/2026, 4/20/2026, and 4/27/2026. LVN 1 stated not receiving the Ozempic doses placed Resident 1 at risk for issues with controlling blood sugar levels. During a concurrent interview and record review on 5/27/2026 at 4:35 p.m., with the Director of Nursing (DON), Resident 1's MAR, for the month of 4/2026, was reviewed. The DON stated the facility did not receive the required high-cost form to sign and was not aware that Resident 1 was needing authorization for Ozempic medication. The DON stated not receiving Buprenorphine Patch on 4/8/2026 and 4/15/2026, placed Resident 1 at risk for unresolved pain. The DON stated staff did not follow up Resident 1's Ozempic and Buprenorphine Patch with the pharmacy. During an interview on 5/28/2026 at 11:16 a.m., with (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pharmacist (Pharm) 1, Pharm 1 stated Resident 1's Ozempic was never dispensed to the facility because it was a high-cost medication requiring facility authorization and documentation. Pharm 1 stated the high-cost form was never received from the facility. During an interview on 5/28/2026 at 12:27 p.m., with Pharm 2, Pharm 2 stated Resident 1's Buprenorphine patch was never dispensed to the facility because it required the PCP's signature. Pharm 2 stated the pharmacy did not receive the Primary Care Physician (PCP) signature and authorization from the facility. During a concurrent interview and record review on 5/28/2026 at 2:13 p.m., with LVN 4, Resident 1's MAR for Buprenorphine Patch, dated 4/22/2026 and 4/29/2026, and Progress Note, dated 4/22/2026, were reviewed. LVN 4 stated to a the box of Buprenorphine Patches were brought by Resident 1's FM to the facility (date unknown). LVN 4 stated the progress notes on 4/22/2026 did not indicate LVN 4 obtained Resident 1's PCP's approval to use Resident 1's Buprenorphine Patches brought from home at the facility. During a concurrent interview and record review on 6/1/2026 at 2:18 p.m., with the DON, Resident 1's MAR for Ozempic, dated 3/30/2026, the MAR for Buprenorphine Patch, dated 4/1/2026, 4/22/2026 and 4/29/2026, the facility's policy and procedures (P&P), titled Medication Ordering and Receiving from Pharmacy, dated 8/2014, and Resident 1's Progress Notes, dated 4/2026, were reviewed. The DON stated both Ozempic on 3/30/2026 and Buprenorphine Transdermal Patch on 4/1/2026, 4/22/2026 and 4/29/2026 should not have been marked off as given, because the medications were never delivered by the pharmacy. The nurses should have followed up with pharmacy. The DON stated she was aware that Resident 1 did not receive the Buprenorphine Patch, and FM brought in two doses from home (date not specified). The DON stated medications brought from home which are to be continued at the facility should be verified by the pharmacist or physician according to the facility's P&P titled Medication Ordering and Receiving from Pharmacy. The DON stated Resident 1's progress notes did not indicate the Buprenorphine patches brought by the resident's FM was verified from the resident's PCP if approved to continue taking the medicine (Buprenorphine patch). During a review of facility's P&P titled, Medication Administration, dated 12/19/2022, the P&P indicated to sign MAR after medications is administered, correct any discrepancies and report to nurse manager. During a review of facility's P&P titled, Medication Ordering and Receiving From Pharmacy, dated 8/2014, the P&P indicated, the use of medications brought to the facility by a family member from home is allowed only when the physical description of the medication have been verified by a pharmacist or physician.