

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/16/2026
NAME OF PROVIDER OR SUPPLIER Sunny Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 one out of three sampled residents' (Resident 2) low air loss (LAL) mattress pump (a small electric machine that constantly blows air into a medical air bed to prevent a pressure ulcer/injury [localized damage to the skin and/or underlying tissue usually over a bony prominence]) from developing or worsening) was set according to Resident 2's weight. This failure placed Resident 2's current pressure ulcers to worsen and had the potential to develop further pressure injuries. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnoses included acute respiratory failure (sudden, life-threatening condition where the lungs cannot give enough oxygen into the blood) with hypoxia (a medical condition where your body's tissues and organs do not get enough oxygen to work properly). During a review of Resident 2's History and Physical (H&P), dated 6/30/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 7/6/2026, the MDS indicated Resident 2 had moderate cognitive impairment (problems with the ability to think, learn, use judgement, and make decisions). Resident 2 required substantial/maximal assistance (helper does more than half the effort) to perform Activities of Daily Living (ADLs) such as toileting hygiene and showering/bathing self. Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to perform movements such as rolling left and right and required partial/moderate assistance (helper does less than half the effort) to change positions from sitting to lying. During a review of Resident 2's Skin Check, dated 6/30/2026, the Skin Check indicated Resident 2 was admitted to the facility with a pressure ulcer to the sacrum (large, triangle-shaped bone at the base of the spine) and with another pressure ulcer to the right buttock. During a review of Resident 2's Order Summary Report, dated 7/1/2026, the Order Summary Report indicated Resident 2 had an order for, LAL Mattress for wound management. Set to resident's weight/comfort. During a review of Resident 2's weight summary, dated 7/16/2026, the weight summary indicated Resident 2 weighed 180 pounds (lbs.) as of 7/13/2026. During an observation on 7/15/2026 at 2:53 p.m., Resident 2's LAL mattress pump (labeled Protekt Aire 4000DX/5000DX) was observed to be set at 400 lbs. During a concurrent observation, interview and record review on 7/15/2026 at 3:28 p.m., with Treatment Licensed Vocational Nurse (LVN) 1, Resident 2's LAL mattress pump was observed and Resident 2's weight, dated 7/13/2026, was reviewed. Resident 2 weighed 180 lbs. and not 400 lbs. Treatment LVN 1 stated Resident 2's pump was set to 400 lbs. Treatment LVN 1 stated Resident 2's LAL mattress pump should have been set to Resident 2's weight of 180 lbs. and comfort. Treatment LVN 1 stated incorrect LAL mattress pump setting could cause Resident 2's wound to decline and possibly allow for more (wounds) to develop. During an (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 7/16/2026 at 8:55 a.m., with Registered Nurse (RN) 1, RN 1 stated licensed staff should have checked the LAL mattress pump at least once a shift to ensure that the settings were correct. During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Prevention and Management, dated 5/18/2026, the P&P indicated, the facility was committed to provide treatment and services to heal the pressure ulcer/injury, prevent infection, and the development of additional pressure ulcers/injuries. The P&P indicated that basic or routine care interventions could include but are not limited to redistribute pressure (such as repositioning, protecting, and/or offloading heels, etc.). During a review of the facility's P&P titled, Pressure Injury Prevention Guidelines, dated 11/27/2023, the P&P indicated, interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, tasks, the frequency of performance. The P&P indicated prevention devices should be utilized in accordance with manufacturer recommendations (e.g., heel flotation devices, cushions, mattresses). During a review of facility's operation manual titled, Proactive Medical Products, Operation Manual for Protekt Aire 4000DX/4600DX/5000DX, the operation manual indicated, users should adjust air mattress to a desired firmness according to the resident's weight or the suggestion from a health care professional.		

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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 observation, interview and record review, the facility failed to ensure a medicine was not left at the resident's bedside and ensure one of three sampled residents (Resident 2), drunk the scheduled medication. This failure resulted in the medication not being taken timely. Findings: During a review of Resident 2's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE]. Resident 2's diagnoses included acute respiratory failure (sudden, life-threatening condition where the lungs cannot give enough oxygen into the blood) with hypoxia (a medical condition where your body's tissues and organs do not get enough oxygen to work properly). During a review of Resident 2's History and Physical (H&P), dated 6/30/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set ([MDS], a resident assessment tool), dated 7/6/2026, the MDS indicated Resident 2 had moderate (not severe or extreme) cognitive impairment (problems with the ability to think, learn, use judgement, and make decisions). Resident 2 required substantial/maximal assistance (helper does more than half the effort) to perform Activities of Daily Living (ADLs) such as toileting hygiene and showering/bathing self. Resident 2 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to perform movements such as rolling left and right and required partial/moderate assistance (helper does less than half the effort) to change positions from sitting to lying. During a review of Resident 2's Order Summary Report, dated 7/1/2026, the Order Summary Report indicated Multiple Vitamins-Minerals Tablet, one tablet by mouth one time a day for wound management. Resident 2's Order Summary Report did not indicate that Resident 2 had orders to self-administer medication. During an observation on 7/16/2026 at 12:43 p.m., in Resident 2's room, a small, round, orange pill was observed inside a medication cup at Resident 2's bedside table. During a concurrent observation and interview on 7/16/2026 at 12:51 p.m., with Licensed Vocational Nurse (LVN) 2, at Resident 2's bedside, LVN 2 stated Resident 2's bedside table had a small, round, orange pill. LVN 2 stated the pill was Resident 2's multivitamin from the morning medications. LVN 2 stated nurses should observe that residents swallow their medications before leaving. LVN 2 stated, leaving Resident 2's medication unattended at the bedside should be avoided. During an interview on 7/16/2026 at 3:40 p.m., the Quality Assurance (QA) Nurse stated there were no residents currently with orders to self-administer medication. During a review of the facility's policy and procedure (P&P) titled, Resident Self-Administration of Medication, dated 12/19/2022, the P&P indicated a resident may only self-administer medications after the facility's IDT (Interdisciplinary Team - a group of healthcare professionals, including physician, nurses, resident/ resident representative, working together to develop a plan of care for the residents) has determined which medications may be administered safely. During a review of facility's P&P titled, Medication Administration, dated 12/19/2022, the P&P indicated, medications should be administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician. The P&P indicated that compliance guidelines included to observe resident consumption of medication.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the prescribed therapeutic diet of one of three sampled residents (Resident 1) was followed. This failure placed Resident 1 at risk for elevated blood sugar levels. 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 Chronic Obstructive Pulmonary Disease ([COPD], a chronic lung disease causing difficulty in breathing) with (Acute [sudden or quick]) Exacerbation (a sudden worsening of symptoms) and Type 2 Diabetes Mellitus ([DM], a disorder characterized by difficulty in blood sugar control and wound healing) with Diabetic Peripheral Angiopathy without Gangrene (high blood sugar which causes narrowing of blood vessels in the arms or legs, reducing blood flow, with no tissues dying or turning black). During a review of Resident 1's History and Physical (H&P), dated 1/30/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set ([MDS], a resident assessment tool), dated 4/23/2026, the MDS indicated Resident 1 had moderate (not severe or extreme) cognitive impairment (problems with the ability to think, learn, use judgement, and make decisions). Resident 1 required substantial/maximal assistance (helper does more than half the effort) to perform Activities of Daily Living (ADLs) such as eating and oral hygiene. Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) to perform movements such as rolling left and right and was dependent (helper does all the effort) to change positions from sitting to standing. During a review of Resident 1's Order Summary Report, dated 7/7/2026, the Order Summary Report indicated an order of Consistent Carbohydrate Diet (CCHO), No Added Salt (NAS) minced and moist ([MM5], Level 5 International Dysphagia Diet Standardization Initiative [IDDSI], a global framework that helps classify the thickness of drinks and texture of foods for people with swallowing difficulties), thin (TN0) consistency (liquids such as water, tea, or clear broth). During a review of Resident 1's dietary slip, dated 7/16/2026, the dietary slip indicated Resident 1 had large portions. During an interview on 7/16/2026 at 1:48 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had large portions indicated on his dietary slip. During an interview on 7/16/2026 at 3:02 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated large portions would be an order that needed to come from the physician. During a concurrent interview and record review on 7/16/2026 at 3:18 p.m., with the Dietary Supervisor (DS), Resident 1's diet order and dietary slip, dated 7/16/2026, were reviewed. DS stated Resident 1 previously had an order for large portions during their previous admission. DS stated Resident 1's current diet order did not indicate that Resident 1 be given large portions. DS stated they had printed large portions on Resident 1's dietary slip because it was a note that was carried over from Resident 1's previous diet orders prior to Resident 1's current admission to the facility. DS stated they should have verified that Resident 1's diet slip matched Resident 1's current diet orders before the dietary slip was printed. DS stated Resident 1 having large portions could have increased their blood sugar levels and declined their health. During an interview on 7/22/2026 at 2:31 p.m., with Registered Nurse (RN) 1, RN 1 stated all diet orders from the physician should be followed and verified because only the physician can determine what orders to continue or discontinue once a resident is readmitted to the facility. During a review of facility's policy and procedure (P&P) titled, Therapeutic Diet Orders, dated 5/17/2023, the P&P indicated, the facility should provide all residents with foods in the appropriate form and/or the (continued on next page)		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate nutritive content as prescribed by a physician. The P&P indicated that dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.		