STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Sunland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 8647 Fenwick Street. Sunland, CA 91040	

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide resident-centered care and services, for one of three sampled residents (Resident 1) by failing to ensure that a required 72-hour neurological assessment (neuro check - an evaluation of neurological [relating to the nerves or the nervous system, which includes the brain, spinal cord, and peripheral nerves that control body functions, movement, and sensation] status) was accurately completed following Resident 1's unwitnessed fall on 12/28/2025. This deficient practice had the potential to cause confusion in the care and services provided to Resident 1 and placed the resident at risk of not receiving appropriate care due to inaccurate or incomplete medical information.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/28/2020 with diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), muscle weakness, and non-displaced fracture of medial malleolus of right tibia (a crack in the bony bump on the inner side of the right ankle, where the broken pieces remain properly aligned). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 12/11/2025, the MDS indicated Resident 1's cognition (a mental process of acquiring knowledge and understanding through thought, experience and the senses) was severely impaired. The MDS indicated Resident 1 required partial/moderate assistance from staff with oral hygiene and required substantial/maximal assistance from staff with toileting hygiene and personal hygiene. During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation- a structured, four-step communication framework, used by nurses to deliver concise, critical patient information, usually to physicians or during handoffs) Communication Form dated 12/28/2025, timed at 8:45 p.m., the SBAR Communication Form indicated Resident 1 had an unwitnessed fall on 12/28/2025, resulting in a bump to the right forehead and severe forehead pain rated at eight (8) out of ten (10) using a pain rating scale (used to assess a resident's pain intensity from 0 [no pain] to 10 [worst pain imaginable]). During an interview and concurrent record review on 1/15/2026 at 10:12 a.m., with the Assistant Director of Nursing (ADON), Resident 1's Neuro Check List with a start date of 12/28/2025 at 8:30 p.m. was reviewed. The ADON stated that a 72-hour neuro check is initiated when a resident experiences an unwitnessed fall. The ADON reviewed Resident 1's 72-hour Neuro Check List dated 12/28/2025 and stated that Resident 1's 72-hour neuro check list was initiated at 8:30 p.m. Upon further review of the 72-hour neuro check documentation, the ADON stated that the assessment intervals were not accurately completed. The ADON stated that the every 30 minute neurological checks (x3) should have been conducted at 9:15 p.m., not 9:00 p.m., and the subsequent 30-minute check should have been completed at 9:45 p.m., not 9:30 p.m. The ADON further stated that 72-hour neurological checks must be accurately assessed and documented because facility staff are required to closely monitor the resident for any acute changes such as alterations in level of consciousness (refers to a person's state of arousal, alertness, and awareness of themselves and their surroundings, ranging from fully awake to (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	unconscious) or pupil (the black, circular opening in the center of the iris that regulates the amount of light entering the eye) size and to immediately report any changes from baseline to the physician for further intervention. The ADON stated reporting any changes from baseline is very important, as such changes may indicate a brain injury related to the fall. The ADON also reviewed Resident 1's Nurse's Note dated 12/28/2025, timed at 9:30 p.m., and stated that Resident 1 was transferred to the General Acute Care Hospital 1 (GACH 1) at 9:30 p.m. During a follow-up concurrent interview and record review on 1/15/2026 at 10:15 a.m., with the ADON, Resident 1's Nurse's Note dated 12/29/2025 was reviewed. The ADON stated that Resident 1 returned to the facility on [DATE] at 5:15 a.m. The ADON reviewed Resident 1's 72-hour neuro check documentation and stated that, because Resident 1's return to the facility was documented at 5:15 a.m. on 12/29/2025, the 72-hour neurological checks should have resumed upon arrival and followed the appropriate assessment intervals as follows: - 12/29/2025 at 5:15 a.m.; 9:15 a.m.; 1:15 p.m.; 5:15 p.m.- 12/30/2025 at 1:15 a.m.; 9:15 a.m.; 5:15 p.m. and- 12/31/2025 at 1:15 a.m.; 9:15 a.m.; 5:15 p.m. The ADON further stated that precise timing of 72-hour neurological checks is critical to ensure staff promptly assess the resident and timely report any changes from baseline to support Resident 1's safety. During a review of the facility's policy and procedure (P&P) titled Neurological Checks, last reviewed on 5/14/2025, the P&P indicated it is the policy of the facility that if a resident sustains a fall and hits his/her head neurological checks will be conducted. The appropriate form will be utilized for proper documentation and timetable for neuro-checks for 72 hours. During a review of the facility's P&P titled Documentation Principles, last reviewed on 5/14/2025, the P&P indicated it is the policy of the facility that resident's clinical record shall be current and kept in detail consistent with good medical and professional practice based on the care provided to each resident. Entries must be accurate, timely, objective, specific, concise, legible, clear, and descriptive.

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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. Based on interview and record review, the facility failed to ensure that pain medication was administered in accordance with the physician's orders based on the documented pain scale for one of three sampled residents (Resident 1). This deficient practice had the potential to result in inadequate pain management for Resident 1.During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 3/28/2020 with diagnoses that included atrial fibrillation (an irregular and often very rapid heart rhythm), muscle weakness, and non-displaced fracture of medial malleolus of right tibia (a crack in the bony bump on the inner side of the right ankle, where the broken pieces remain properly aligned). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 12/11/2025, the MDS indicated Resident 1's cognition (a mental process of acquiring knowledge and understanding through thought, experience and the senses) was severely impaired. The MDS indicated Resident 1 required partial/moderate assistance from staff with oral hygiene and required substantial/maximal assistance from staff with toileting hygiene and personal hygiene. During a review of Resident 1's Order Summary Report with order date of 6/29/2025, the Order Summary Report indicated an order for Acetaminophen (known as Tylenol - brand name, a medication used to relieve mild to moderate pain) 325 milligrams (mg- unit of measurement). Give two tablets by mouth every four (4) hours as needed for mild pain (a rating of one to four on a zero [0- no pain] to ten [10- worst pain imaginable numerical pain scale [used to assess a resident's pain intensity]) scale 1 to 4/10. During a review of Resident 1's care plan regarding at risk for chronic pain/discomfort related to chronic physical or psychosocial impairment, reviewed in December 2025, the care plan indicated the following intervention: Provide consistent and sufficient medication for pain relief, tailored to the individual. During a review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation- a structured, four-step communication framework, used by nurses to deliver concise, critical patient information, usually to physicians or during handoffs) Communication Form dated 12/28/2025, timed at 8:45 p.m., the SBAR Communication Form indicated Resident 1 had an unwitnessed fall on 12/28/2025, resulting in a bump to the right forehead and severe forehead pain rated at eight (8) out of ten (10) using a pain rating scale (used to assess a resident's pain intensity from 0 [no pain] to 10 [worst pain imaginable]). The SBAR Communication Form indicated ice pack and Tylenol (dose not specified) were provided. During a review of Resident 1's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of December 2025, the MAR indicated that Resident 1 was administered Acetaminophen on 12/28/2025 at 8:45 p.m. for forehead pain, with a documented pain level of seven (7). During an interview on 1/14/2026 at 11:47 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated that Resident 1 had an unwitnessed fall on 12/28/2025 at around 8:30 p.m. LVN 1 stated that Resident 1 complained of forehead pain rated at 8/10, and LVN 1 administered Acetaminophen for the reported 8/10 pain. LVN 1 further stated that Resident 1's physician was not contacted for stronger pain medication because Resident 1 had only a small bump on the forehead and LVN 1 thought that administering Acetaminophen was appropriate. LVN 1 stated that the pain level documented as seven in the MAR dated 12/28/2025 was incorrect and that the pain level should have been documented as eight, as reported by Resident 1. During an interview and concurrent record review on 1/15/2026 at 10:15 a.m., with the Assistant Director of Nursing (ADON), Resident 1's MAR for the month of December 2025 was reviewed. The ADON stated that on 12/28/2025 at 8:45 p.m., Resident 1 was administered Acetaminophen 325 mg, two (2) tablets, for a reported pain level of 7/10. The ADON stated that Acetaminophen should not have been administered as the order is for pain levels 1-4/10. The ADON further stated that LVN (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 should have contacted Resident 1's physician to request an order for a stronger pain medication appropriate to Resident 1's documented pain level of 8/10. The ADON stated that by not providing appropriate medication, Resident 1's pain may not have been adequately alleviated and may have been prolonged. During a review of the facility's policy and procedure (P&P) titled, Pain Management Protocol, last reviewed on 5/14/2025, the P&P indicated Purpose: 4. Intervening to treat pain before the pain becomes severe. Wherever the presence of pain is indicated, the process of pain assessment and management begins. At the identification of pain, the pain rating should always be included in the documentation. Medical records will monitor the implementation of this policy. During a review of the facility's P&P titled Medication Administration, last reviewed on 5/14/2025, the P&P indicated it is the policy of the facility that medications for residents be administered in a safe and timely manner, and as prescribed. Medications should be administered in accordance with the physician's orders. If the dosage is believed to be inappropriate or excessive for a resident. the licensed nurse administering the medication should contact the resident's attending physician, physician's assistant, nurse practitioner or Medical Director to discuss the concerns