STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056031	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunland Post Acute	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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to ensure that a Significant Change in Status Minimum Data Set (MDS- a resident assessment tool) assessment was completed for one of five residents (Resident 5) when the resident had a significant decline in two areas (skin condition and functional status) from baseline, as compared to the most recent comprehensive assessment, and did not return to baseline within two weeks.This deficient practice had the potential to negatively impact the provision of necessary care and services.During a review of Resident 5's admission Record, the admission Record indicated the facility originally admitted Resident 5 on 1/20/2026 and was readmitted on [DATE] with diagnoses that included intervertebral disc degeneration (a condition that occurs when your spinal disks wear down) of the thoracic region (the chest area, located between the neck and the abdomen), Stage 3 (full thickness loss of skin, dead and black tissue may be visible) pressure ulcer/pressure injuries (localized damage to the skin and or underlying tissue usually over bony prominence) to the left buttock, and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage caused by long term high blood sugar causing numbness or weakness in the hands and feet). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 1/23/2026, the MDS indicated Resident 5 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), no pressure ulcer/injuries and that Resident 5 required maximal assistance from staff for toileting hygiene, tub/shower transfers, lower body dressing, sit-to-lying, and lying-to-sitting on the side of bed. During a review of Resident 5's Skin and Body assessment dated [DATE], the Skin and Body Assessment indicated that Resident 5 had a Stage 3 pressure ulcer/injury to the left buttock. During a review of Resident 5's Weekly Pressure Injury Records dated 3/24/2026, 3/31/2026, and 4/7/2026, the Weekly Pressure Injury Record indicated the continued presence of a Stage 3 pressure ulcer/injury to the left buttock. During a review of Resident 5's Occupational Therapy (OT - focuses on helping residents regain independence in daily activities - such as dressing, bathing and eating) Therapy Progress Report, Date of Service 4/1/2026 through 4/7/2026, the OT Therapy Progress Report indicated a decline in functional status for lower body dressing. The OT Therapy Progress Report indicated prior level of function (PLOF) for lower body dressing as Minimal assist, with baseline (3/18/2026), previous (3/31/2026), and current (4/7/2026) status all reflecting Total Dependence with attempts to initiate. During a review of the Resident Assessment Instrument (RAI), Chapter 2, last reviewed on 5/14/2025, the RAI Chapter 2 indicated Significant Change in Status Assessment (SCSA) must be completed when the Interdisciplinary Team (IDT - a collaborative group of professionals who work together to create, manage, and implement a unified, person-centered plan of care for residents) determines that a resident meets the significant change guidelines for either major improvement or decline, an SCSA is required when a significant change (either improvement or decline) in resident's condition from baseline is identified/ has occurred through comparison of the resident's current status with the most recent comprehensive assessment and subsequent quarterly assessments, and the resident condition is not expected to return to baseline within two weeks. During an interview on (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/22/2026 at 10:35 a.m., with MDS Coordinator Nurse (MDSCN), the MDSCN stated that in comparison to Resident 5's most recent MDS admission and 5-Day Assessment (Comprehensive) with an Assessment Reference Date of 1/23/2026, the resident's condition from 3/18/2026 through 4/7/2026 reflected a significant decline. This included a decline in Resident 5's skin condition, evidenced by the development of a Stage 3 pressure ulcer, and a decline in functional status, with the resident becoming totally dependent in lower body dressing with attempts to initiate. The MDSCN stated that the resident's condition did not return to baseline within two weeks (3/18/2026 to 4/7/2026) therefore an SCSA should have been completed. The MDSCN further stated that failure to complete the SCSA and update the care plan delayed the provision of necessary care and services for Resident 5. During an interview on 4/22/2026 at 3:45 p.m., with the Director of Nursing (DON), the DON stated that an SCSA should have been completed by the MDSCN. The DON further stated that failure to complete the SCSA and revise the care plan resulted in a delay in the delivery of care and services needed to meet the resident's needs. During a review of the facility`s policy and procedure (P&P) titled, Resident Assessment Instrument (RAI) Process last reviewed on 5/14/2025, the policy indicated the facility will utilize the Resident Assessment Instrument (RAI) process for the accurate assessment of each resident's functional capacity and health status. During a review of Resident Assessment Instrument (RAI) Chapter 2 (P&P) titled, Significant Change in Status Assessment (SCSA) last reviewed on 5/14/2025, the policy indicated Significant Change in Status Assessment (SCSA) must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline, a SCSA is appropriate when there is a determination that a significant change (either improvement or decline) in resident's condition from their baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments, and the resident condition is not expected to return to baseline within two weeks.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate documentation in the residents' clinical records for two of five sampled residents (Resident 4 and Resident 5), in accordance with accepted medical and professional standards and consistent with the care provided. This deficient practice had the potential to negatively affect the plan of care and the delivery of necessary care and services for these residents. a. During a review of Resident 4's admission Record, the admission Record indicated the facility originally admitted Resident 4 on 3/23/2026 and was readmitted on [DATE] with diagnoses that included radiculopathy (a condition caused by compression or irritation of a nerve root in the lower spine) of the lumbar region (lower back), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and intervertebral disc degeneration (a condition that occurs when your spinal disks wear down) of the lumbar region without mention of lumbar back pain or lower extremity pain. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool) dated 3/27/2026, the MDS indicated that Resident had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), no pressure ulcer/pressure injuries (localized damage to the skin and or underlying tissue usually over bony prominence) and required maximal staff assistance with toileting hygiene, showering/bathing, sit-to-lying, lying-to-sitting on the side of the bed, and toilet transfers. During a review of Resident 4's CBC with differential (a standard blood test that measures the cells in your blood to evaluate overall health, detect infections, blood and immune system disorder) laboratory result dated 4/15/2026, the CBC with differential laboratory result had a handwritten note indicated seen and reviewed 4/16/2026, awaiting orders. During an interview on 4/22/2026 at 11:25 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated that the physician responded the same day to the CBC with differential laboratory results dated [DATE] with no new orders, however, he (LVN 4) did not document the physician's response because it was busy that day. LVN 4 stated that he should have documented it because it could have negatively affected Resident 4's plan of care and delayed the provision of necessary care and services that Resident 4 needs. b. During a review of Resident 5's admission Record, the admission Record indicated the facility originally admitted Resident 5 on 1/20/2026 and was readmitted on [DATE] with diagnoses that included intervertebral disc degeneration (a condition that occurs when your spinal disks wear down) of the thoracic region (the chest area, located between the neck and the abdomen), Stage 3 (full thickness loss of skin, dead and black tissue may be visible) pressure ulcer/pressure injuries (localized damage to the skin and or underlying tissue usually over bony prominence) to the left buttock, and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage caused by long term high blood sugar causing numbness or weakness in the hands and feet). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 1/23/2026, the MDS indicated Resident 5 had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), no pressure ulcer/injuries and that Resident 5 required maximal assistance from staff for toileting hygiene, tub/shower transfers, lower body dressing, sit-to-lying, and lying-to-sitting on the side of bed. During a review of Resident 5's Skin and Body assessment dated [DATE], the Skin and Body Assessment indicated that Resident 5 had a Stage 3 pressure ulcer/injury to the left buttock. During a review of Resident 5's Weekly Pressure Injury Records dated 3/24/2026, 3/31/2026, and 4/7/2026, the Weekly Pressure Injury Record indicated the continued presence of a Stage 3 pressure ulcer/injury to the left buttock. During a review of Resident 5's Discharge Skin and Body assessment dated [DATE], the Discharge Skin and Body Assessment indicated that Resident 5 had intact skin with no documented pressure (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ulcers/pressure injuries (localized damage to the skin and or underlying tissue usually over bony prominence). During an interview on 4/22/2026 at 12:39 p.m., with Registered Nurse 2 (RN 2), RN 2 stated that Resident 5 was transferred via 911 (emergency telephone number used to immediately request help from emergency medical services) and she (RN 2) was in a hurry to complete the discharge form and was not able to double check that Resident 5 had a Stage 3 pressure ulcer/injury. RN 2 stated she should have documented accurately, as the omission could have negatively affected Resident 5's plan of care in the general acute care hospital (GACH). During an interview on 4/22/2026 at 3:45 p.m., with the Director of Nursing (DON), the DON stated that nurses are expected to accurately document the care they provide, as incomplete or inaccurate documentation can negatively impact the resident's plan of care. During a review of the facility`s policy and procedure (P&P) titled, Documentation Principles last reviewed on 5/14/2025, the facility policy indicated that resident's clinical records 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.