

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  12/04/2025
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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>(continued on next page)</p>

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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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure the prescribing provider obtained informed consent from a resident's responsible party for the use of a physical restraint (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body i.e. [wander guard], a bracelet that a resident wears that alarms when he attempts to exit the facility) for one of one of one resident investigated for the use of restraints. This deficient practice had the potential for the responsible party to not be informed regarding decisions that may affect Resident 47's health conditions. Findings: During a review of Resident 47's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following stroke (loss of blood flow to a part of the brain) affecting the left side, and aphasia (a disorder that makes it difficult to speak). During a review of Resident 47' s Minimum Data Set (MDS, a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 47 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 47 was able to walk 10 feet in the hallway with partial assistance (helper does less than half the effort). The MDS indicated Resident 47 has not exhibited wandering behavior. During a review of Resident 47's History and Physical (H&amp;P), dated 5/17/2025, the H&amp;P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 47's Physician's Orders, the orders indicated the following: May have wander guard in place, dated 5/15/2025 and discontinued on12/02/2025. Monitor blue wearable wander guard in place, dated 5/15/2025 and discontinued on 12/02/2025. During a review of Resident 47's Informed Consent for use of a Wander Guard, dated 5/15/2025, the Informed Consent indicated Resident 47 was self-responsible and unable to sign. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 12/04/2025 at 8:20 a.m., reviewed the policy for physical restraints and Resident 47's medical records including informed consents, H&amp;P dated 5/17/2025, and Interdisciplinary Team (IDT, a group of disciplines such as nursing, physician, and social services who meet with a resident or their responsible party to discuss interventions for their medical plan of care) Care Plan Conference Summary dated 8/25/2025. RN 1 stated that the policy indicated the wander guard is considered a restraint. RN 1 stated that Resident 47's Informed Consent for use of a wander guard indicated Resident 47 was self-responsible and unable to sign because at that time, the facility was unaware Resident 47 had family. RN 1 stated that after the facility was notified Resident 47 had family (unable to state the specific date), they (licensed nurses) should have obtained the resident's responsible party a written consent. RN 1 stated Resident 47's History and Physical indicated the resident does not have the capacity to understand and make decisions and it was important to ensure the resident's responsible party is fully informed of his (Resident 47) care so they would be able to make medical decisions on his behalf. RN 1 stated the IDT Care Plan Conference Summary, dated 8/25/2025 indicated Resident 47's family member was contacted for the IDT meeting but had not returned the phone call and was not at the care plan meeting. RN 1 stated that the facility was aware that Resident 47 had family as of at least 8/25/2025. During a review of the facility's policy and procedure (P&amp;P) titled, Physical Restraints, last reviewed on 5/14/2025, the P&amp;P indicated the informed consent for the physical restraint is required to be obtained from the resident or legal representative. During a review of the facility's P&amp;P titled, Resident Rights, last reviewed on 5/14/2025, the P&amp;P indicated the resident/representative to receive all information, in advance, of risks and benefits of proposed, care, treatment, alternatives, and choose the alternative of choice which includes information for the administration of physical restraints.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Based on interview and record review the facility failed to implement the facility's policy and procedure titled Advance Directives, for two of three residents (Resident 3 and Resident 2) reviewed under the Advance Directive Care area by failing to: 1. Maintain a copy of Resident 3's Advance Directive in the resident's medical record. 2. Ensure that Resident 1 was provided written information concerning the resident's right to prepare an Advance Directive. These deficient practices had the potential for the facility to not honor the resident's medical decisions regarding end-of-life treatment and had the potential to cause conflict with Resident 3 and 2's wishes regarding their medical care. Findings:</p> <p>1. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 9/18/2023 with diagnoses including Alzheimer's disease (a progressive brain disorder causing nerve cell damage, leading to memory loss, thinking difficulties, and behavioral changes) and hypertension (high blood pressure).</p> <p>During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 9/12/2025, the MDS indicated the resident had the ability to usually make self- understood and the ability to usually understand others. The MDS indicated Resident 3 required substantial/maximal assistance with oral hygiene, shower, upper body dressing and dependent on staff for toileting, lower body dressing and putting on and taking off footwear.</p> <p>During a concurrent interview and record review on 12/3/2025 at 8:24 a.m., with Registered Nurse 2 (RN 2), Resident 3's Advance Directive Acknowledgement Form dated 12/13/2023 (ADAF) was reviewed. RN 2 stated that Resident 3's Advance Directive Acknowledgement Form indicated that Resident 3 has executed an advance directive. During review of Resident 3's electronic medical record and physical chart, RN 2 verified that there was no copy of the advance directive in Resident 3's electronic medical record or physical chart. RN 2 stated that an advance directive would indicate the resident's healthcare wishes and it is important to have it accessible during an emergency so facility staff can determine whether the resident has chosen full treatment or not. RN 2 stated that it is a violation of the Resident 3's rights if his/her healthcare wishes are not honored.</p> <p>During a review of the facility's policy and procedure (P&amp;P), titled Advance Directive, last reviewed on 5/14/2025, the P&amp;P indicated that it is the policy of the facility that a resident may develop an advance directive relative to his/her refusal of medical or surgical treatment, which will be followed in accordance with this policy and procedure and current State Law. the resident or their responsible party will be asked if the resident has completed an advance directive, and provide a copy of the document for the resident's clinical record.</p> <p>2. During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 to the facility on 6/12/2024 and readmitted the resident on 11/30/2024 with diagnoses including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), pyelonephritis (a urinary tract infection [UTI] that occurs when bacteria enter the urinary tract [drainage system to urinate] and travel up to one or both kidneys [body organ that filters and remove waste from the blood]) and lack of coordination.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During review of Resident 2's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 9/24/2025, the MDS indicated Resident 2 has an intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required moderate to maximal assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).</p> <p>During a concurrent interview and record review on 12/2/2025 at 9:33 a.m., with the Social Service Director (SSD), Resident 2's electronic and physical chart was reviewed. The SSD stated that she could not locate Resident 2's Advance Directive Acknowledgement form. The SSD stated that upon admission they are supposed to check with the resident or the resident's representative if the resident has an advance directive and if the resident does not have one, they have to offer information on how to formulate one. The SSD stated it is important to check for an advance directive to ensure the facility is aware of the resident or the resident representative's wishes regarding medical care.</p> <p>During an interview on 12/4/2025 at 8:28 a.m., with the Director of Nursing (DON), the DON stated that it is important to check whether or not the resident or resident representative has executed an advance directive and/or provide information on how to formulate one on admission to ensure the facility is aware of the resident's wishes regarding their health care.</p> <p>During a review of facility's policy and procedure (P&amp;P), titled, Advance Directives, reviewed on 5/14/2025, the P&amp;P indicated, Prior to, or upon admission, resident will be provided with written information concerning the resident's rights under the State law to prepare an advance directive.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to inform a resident's responsible party (one who makes medical decisions for a resident who is unable to make their own decisions), that the resident was placed on one-to-one monitoring (when one staff stays with a resident at all times to ensure the safety of the resident), for one (Resident 47) of seven residents reviewed under the care area of accidents. This deficient practice had the potential to violate Resident 47's representative's right to be informed of the treatment and services provided to Resident 47. Findings: During a review of Resident 47's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following stroke (loss of blood flow to a part of the brain) affecting the left side, and aphasia (a disorder that makes it difficult to speak). During a review of Resident 47's Minimum Data Set (MDS, a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 47 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 47 was able to walk 10 feet in the hallway with partial assistance (helper does less than half the effort). The MDS indicated Resident 47 has not exhibited wandering behavior. During a review of Resident 47's History and Physical (H&amp;P), dated 5/17/2025, the H&amp;P indicated the resident does not have the capacity to understand and make decisions. During an observation on 12/01/2025 at 10:02 a.m. observed Resident 47 in his bed sleeping. Certified Nursing Assistant 1 (CNA 1) was standing inside the resident's room. CNA 1 stated she is watching Resident 47 because he tries to go outside of the facility. During a review of Resident 47's most current and past Physician's Orders on 12/1/2025, there was no order for a one-to-one sitter. During a review of Resident 47's Physician's Orders, the orders indicated the following: -May have wander guard (a bracelet that a resident wears that alarms when he attempts to exit the facility) in place, dated 5/15/2025 and discontinued on 12/02/2025. -Monitor blue wearable wander guard in place, dated 5/15/2025 and discontinued on 12/02/2025. During a review of Resident 47's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 10/24/2025, the SBAR indicated Resident 47 removed both wander guards. During a review of Resident 47's Elopement (the act of leaving a facility unsupervised and without prior authorization) Risk Assessment, dated 5/15/2025, the assessment indicated Resident 47 is assessed to be at risk for elopement; is ambulatory and exhibits wandering behavior; cognitively impaired, and obtained an order for wander guard placement due to elopement risk. During a review of Resident 47's Care Plan for Risk for Elopement, dated 5/15/2025, the care plan indicated a goal that Resident 47 will remain in the facility without episodes of elopement daily for 90 days. The care plan did not indicate an intervention with an order for one-to-one sitter. During a telephone interview with Resident 47's responsible party (RP) on 12/03/2025 at 12:16 p.m., the RP stated that she was told by another family member who was the former responsible party (FRP) that Resident 47 removed his wander guard and refused to have one be reapplied. When asked if she was aware that Resident 47 had a one-to-one sitter, the RP stated neither she nor the FRP has been notified by the facility. During a concurrent interview and record review with the Director of Staff Development (DSD) on 12/03/2024 at 3:25 p.m., reviewed the CNA Assignment Sheets dated 10/28/25 for all three shifts. The DSD stated that Resident 47 was first assigned a one-to-one sitter during the 3 p.m. to 11 p.m. shift on 10/28/2025. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 12/03/2025 at 3:30 p.m., Resident 47's SBAR form, dated 10/24/2025 and CNA assignment sheets dated 10/28/2025 were reviewed. RN 1 stated the SBAR form dated 10/24/2025 indicated Resident 47 removed his wander guards and refused to have them placed back on and that the resident's FRP was notified by phone. RN 1 stated the FRP was not notified Resident 47 was assigned a one-to-one sitter because one had not been assigned to him until 10/28/2025. RN 1 could not find any other documentation that the FRP or the RP was notified of Resident 47 being assigned a one-to-one sitter. RN 1 stated it is important for the resident's responsible party to be notified of the resident requiring a one-to-one sitter because that is a change in condition. During a concurrent interview and record review with the Director of Nurses on 12/04/2025 at 12:36 p.m., Resident 47's SBAR, dated 10/24/2025 and CNA assignment sheets dated 10/28/2025 were reviewed. The DON confirmed that Resident 47's FRP or RP were not notified of the one-to-one sitter assignment to the resident. The DON</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>(continued on next page)</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide in writing the completed Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN, a notification to the resident or responsible party [RP] of the potential liability charges for services not covered when the resident was discharged from Medicare Part A services [Medicare that helps pay inpatient care in a hospital, critical access hospital or a skilled nursing facility] with benefit days remaining) for one (Resident 43) of three sampled residents reviewed during the Beneficiary Notification task. This deficient practice had the potential to result in Resident 43 or their representative not being able to exercise their rights to be informed in advance of financial responsibilities, request an expedited review upon appeal, or determine in advance the course of their care. Findings: During a review of Resident 43's admission Record, the admission Record indicated the facility admitted the resident to the facility on 6/19/2025 with diagnoses including diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 43's Minimum Data Set (MDS, a resident assessment tool), dated 9/22/2025, the MDS indicated Resident 43 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 43 needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 43's SNF ABN form, undated, the form indicated Resident 43 no longer met the Medicare part A guidelines for skilled nursing care and rehab services. Resident 43's SNF ABN form indicated Resident 43's last covered day was 8/21/2025 and beginning on 8/22/2025, the resident may have to pay out of pocket for this care if the resident does not have other insurance that may cover these costs. The SNF ABN form was not completed for the selection of the following: Option 1. I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN . Option 2. I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed. Option 3. I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay. The SNF ABN form indicated the facility spoke with Resident 43's Responsible Party (RP 43), where the form indicated Signature of Patient or Authorized Representative on 9/09/2025, 19 days after the last covered day. During a concurrent interview and record review with the Accounts Receivables Supervisor (ARS) on 12/04/2025 at 10 a.m., Resident 43's SNF ABN form was reviewed. The ARS confirmed that Resident 43's responsible party, was notified on 9/09/2025 that Resident 43's last covered day was 8/21/2025. The ARS stated that the form should have been given 72 hours before the last covered day. The ARS stated this is important to ensure that a resident can appeal the decision and possibly have services extended longer than the last covered day. During a concurrent interview and record review with the Director of Nurses (DON) on 12/04/2025 at 1 p.m., reviewed Resident 43's SNF ABN form. The DON stated Resident 43's responsible party should have been notified three days prior to the last covered day. The DON stated this is important to make sure the residents and RPs are aware of the last day of covered services and to ensure they are aware of the right to appeal the decision. During an interview with the ARS on 12/04/2025 at 3:30 p.m., the ARS stated the facility does not have a policy for beneficiary notices but follows the Centers for Medicare and Medicaid Services (CMS, is a federal agency under the U.S. Department of Health and Human Services (HHS) that administers Medicare [insurance program for those greater than [AGE] years old] and Medicaid [a joint federal and state program providing health coverage for low-income individuals] guidelines) guidelines for beneficiary notices. During a review of the CMS Medicare Claims Processing Manual, Chapter 30, Section 70, issued 10/31/2024, the manual indicated prior to the delivery of the SNF ABN a facility needs to provide enough time for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on observation, interview, and record review, the facility failed to maintain residents' privacy of confidential information when Licensed Vocational Nurse 3 (LVN 3) stepped away and left the computer on the medication cart in Station 3 unlocked and unattended. This deficient practice had the potential to violate the right to privacy of all residents in the facility. Findings: During a concurrent observation and interview on 12/03/2025 at 11:37 a.m., with Registered Nurse 5 (RN 5) observed Station 3 Medication Cart with the computer screen open that provided access to resident's electronic health records (EHR- a digital version of a patient's paper chart). RN 5 stated, when a licensed nurse leaves the medication cart, they are to lock the computer so no one will have access to residents' records. RN 5 stated this is important to ensure residents' records are kept private. During a concurrent observation and interview on 12/03/2025 at 11:42 a.m., with Licensed Vocational Nurse 3 (LVN 3) observed the Station 3 medication cart computer screen open. LVN 3 stated she stepped away from the medication cart and should have locked the computer to prevent anyone from having access to residents' records. During an interview with the Director of Nurses (DON) on 12/04/2025 at 1:05 p.m., the DON stated that licensed nurses should lock the computer when leaving the medication cart. The DON stated it is important to maintain residents' privacy. The DON stated leaving a computer open, although not open to a particular residents' record on the computer screen, could potentially allow anyone to access residents' records. The DON stated residents' information must be kept private. During a review of the facility's policy and procedure (P&amp;P) titled, Resident Rights, last reviewed on 5/14/2025, the P&amp;P indicated residents are to be assured confidential treatment of financial and medical records and to approve or refuse their release, except as authorized by law.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for three of five sampled residents (Residents 61, 17, and 76) when: 1. Resident 61's tray table was not kept clean and free of clutter during mealtime. This deficient practice had the potential to negatively impact Resident 61's quality of life, and placing Resident 61 at risk for not properly eating during mealtimes. 2. An alarm located near Resident 17 and Resident 76's rooms activated each time a staff member exited and entered through the smoking patio gate. This deficient practice denied Residents 17 and 76 the right to a comfortable, homelike environment and had the potential to negatively impact their quality of life. Findings:</p> <p>1. During a review of Resident 61's admission Record admission Record indicated the facility originally admitted Resident 61 on 1/20/2022 and readmitted the resident on 3/4/2024 with diagnoses including paroxysmal atrial fibrillation (an irregular rapid heart rate that commonly causes poor blood flow), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and generalized muscle weakness.</p> <p>During review of Resident 61's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 10/22/2025, the MDS indicated Resident 61 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required supervision assistance needed from staff with most of activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).</p> <p>During a concurrent observation and interview on 12/1/2025 at 9:58 a.m., with Registered Nurse 2 (RN 2), in Resident 61's room, Resident 61's breakfast meal tray was observed on the tray table, along with other items. RN 2 stated Resident 61's tray table was dirty and cluttered with unnecessary things in it such as an opened disinfectant wipes container, gloves, masks, disposable undergarments and plastic bags. RN 2 stated that resident's tray table should be clean, tidy and uncluttered during mealtimes.</p> <p>During an interview on 12/4/2025 at 8:28 a.m., with the Director of Nursing (DON), the DON stated that residents' rooms should always be clean and clutter free to promote a homelike environment. The DON also stated that the tray table should always be clean and neat with no other things in it except the meal tray during mealtimes.</p> <p>During a review of facility's policy and procedure (P&amp;P), titled, Comfortable Environment, reviewed on 5/14/2025, the P&amp;P indicated, Facility to maintain a safe, clean, comfortable environment for residents.</p> <p>2. During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted the resident to the facility on 7/27/2017 and readmitted the resident on 11/10/2025 with diagnoses including, but not limited to, acute pyelonephritis (kidney infection), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and difficulty in walking.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Sunland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  8647 Fenwick Street. Sunland, CA 91040	
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 17's History and Physical (H&amp;P) dated 11/13/2025, the H&amp;P indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 17's MDS, dated [DATE], the MDS indicated the resident had adequate hearing, was cognitively intact (able to think, learn, and remember clearly), and needed moderate assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a review of Resident 76's admission Record, the admission Record indicated the facility admitted the resident to the facility on 4/27/2023 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), depression, and generalized muscle weakness.</p> <p>During a review of Resident 76's H&amp;P dated 11/30/2025, the H&amp;P indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 76's MDS, dated [DATE], the MDS indicated the resident had adequate hearing, was cognitively intact, and required light assistance by setting up or cleaning up with most ADLs.</p> <p>During an observation period of two hours on 12/4/2025 between 7:30 a.m. and 9:30 a.m. the alarm for the smoking patio gate activated inside the facility 34 times at 7:38 a.m., 7:41 a.m., 7:42 a.m., 7:42 a.m. again, 7:44 a.m., 7:56 a.m., 7:57 a.m., 7:59 a.m., 8:01 a.m., 8:03 a.m., 8:09 a.m., 8:15 a.m., 8:16 a.m., 8:18 a.m., 8:23 a.m., 8:23 a.m. again, 8:28 a.m., 8:29 a.m., 8:29 a.m. again, 8:30 a.m., 8:32 a.m., 8:33 a.m., 8:40 a.m., 8:45 a.m., 8:49 a.m., 8:59 a.m., 9:02 a.m., 9:04 a.m., 9:04 a.m. again, 9:06 a.m., 9:07 a.m., 9:15 a.m., 9:19 a.m., and 9:24 a.m.</p> <p>During a concurrent observation and interview on 12/4/2025 at 7:38 a.m. observed the Central Supply (CS) staff open the smoking patio gate setting the alarm off. The CS staff stated the alarm goes off inside often because facility staff only has two seconds to put in the code to deactivate the alarm and it is not long enough. The CS staff stated facility staff has to enter and exit through the gate to go to the laundry and maintenance storage areas and they also use it to get to the parking area behind the facility.</p> <p>During a concurrent observation and interview on 12/4/2025 at 8:16 a.m., observed Janitor (JN) 1 enter the smoking patio gate setting the alarm off. JN 1 stated he had been using the smoking patio gate to retrieve equipment located on the other side of the gate that he needed to clean the patio.</p> <p>During an interview on 12/4/2025 at 8:55 a.m. with Resident 76, Resident 76 stated he can hear the alarm going off frequently while he is in his room. Resident 76 stated it goes off all the time every day, including at night. Resident 76 stated when the alarm first started going off a lot it would bother him, but now he has become used to the noise. Resident 76 stated it is now like background noise to him.</p> <p>During an interview on 12/4/2025 at 12:05 p.m. with Resident 17, Resident 17 stated when the door to his room is open the sound of the alarm bothers him because it is right by him. Resident 17 stated people often forget to close the door to his room and then the alarm sound is very loud. Resident 17 stated he always keeps the door to his room closed because of the noise.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/4/2025 at 1:58 p.m. with the Director of Nursing (DON), the DON stated the facility should have a calm, homelike environment with no excessive noise level so residents can rest comfortably and sleep. The DON stated the smoking patio alarm could disrupt the calm environment and bother the residents especially the ones with rooms near the smoking patio door.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Comfortable Environment, last reviewed 5/14/2025, the P&amp;P indicated it is the policy of the facility to maintain a safe, clean, comfortable environment for the residents.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to follow its policy and procedure (P&amp;P) on physical restraint to ensure residents were free from any physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) by failing to ensure there was documentation supporting the use of the wander guard (a bracelet that a resident wears that alarms when he attempts to exit the facility) for one of one of one resident investigated for the use of restraints. This deficient practice had the potential to result in psychological harm for Resident 47. Findings: During a review of Resident 47's admission Record, the admission Record indicated the facility admitted the resident to the facility on 5/14/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following stroke (loss of blood flow to a part of the brain) affecting the left side, and aphasia (a disorder that makes it difficult to speak). During a review of Resident 47's Minimum Data Set (MDS, a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 47 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 47 was able to walk 10 feet in the hallway with partial assistance (helper does less than half the effort). The MDS indicated Resident 47 has not exhibited wandering behavior. During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 47 was able to walk 150 feet in the hallway with supervision or touching assistance (helper provides verbal cues and/or touching/steadying as resident completes the activity). The MDS indicated Resident 47 has not exhibited wandering behavior. During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 47 was able to walk 150 feet in the hallway with setup or clean-up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity). The MDS indicated Resident 47 has not exhibited wandering behavior. During a review of Resident 47's History and Physical (H&amp;P), dated 5/17/2025, the H&amp;P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 47's Physician's Orders, the orders indicated the following: -May have wander guard in place, dated 5/15/2025 and discontinued on 12/02/2025. -Monitor blue wearable wander guard in place, dated 5/15/2025 and discontinued on 12/02/2025. During a review of Resident 47's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 10/24/2025, the SBAR indicated Resident 47 removed both wander guards. During a review of Resident 47's Interdisciplinary Team (a group of disciplines such as nursing, physician, and social services who meet with a resident or their responsible party to discuss interventions for their medical plan of care) Care Plan Conference Summary, dated 5/15/2025, the IDT meeting indicated Resident 47 exhibits wandering behavior. During a review of Resident 47's IDT Care Plan Conference Summary, dated 8/25/2025, the IDT Care Plan Conference Summary indicated there was no documentation regarding the use of a wander guard or wandering behavior. The IDT Care Plan Conference Summary indicated family was contacted for the IDT meeting but had not returned the phone call and were not at the care plan meeting. During a review of Resident 47's Elopement (the act of leaving a facility unsupervised and without prior authorization) Risk Assessment, dated 5/15/2025, the assessment indicated Resident 47 was assessed to be at risk for elopement; is ambulatory and exhibits wandering behavior; cognitively impaired, and obtained an order for a wander guard due to elopement risk. During a review of Resident 47's Elopement Risk Assessment, reviewed 8/25/2025, the assessment indicated Resident 47 was not risk for elopement. During a review of Resident 47's Elopement Assessment, reviewed 11/14/2025, the assessment indicated Resident 47 was at risk for elopement. During a review of Resident 47's Care Plan for Risk for Elopement, dated 5/15/2025, the care plan indicated a goal that Resident 47 will remain in the facility without episodes of elopement daily for 90 days. The care plan indicated an intervention for Resident 47 to wear a wander guard on arm or leg as ordered, placement and function placed. During a review of Resident 47's Resident Monitoring Sheets (a document that indicates where a resident is located each hour in the facility) from 5/15/2025 until 12/04/2025, the monitoring sheets indicated Resident 47's whereabouts in the facility hourly</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to develop and implement a comprehensive care plan (a document that outlines a resident's healthcare needs, goals, and the interventions planned to achieve those goals) that meets the care/services based on the resident's individual assessed needs for three of 23 sampled residents (Resident 76, 81 and 85) by failing to: 1.Ensure safety and supervision during smoking were addressed in Resident 76's and 85's care plans. This deficient practice had the potential to place the residents at risk for smoking-related injuries. 2. Ensure Resident 81's prescribed Klonopin (an anti-anxiety medication) black box warning (the strongest safety alert for prescription drugs) was addressed in Resident 81's care plan. This deficient practice had the potential to place Resident 81 at risk for experiencing adverse effects (harmful, undesired reactions) from Klonopin.</p> <p>Findings:</p> <p>1.a. During a review of Resident 76's admission Record, the admission Record indicated the facility admitted Resident 76 on 4/27/2023 with diagnoses including chronic obstructive pulmonary disease (a progressive lung condition that makes breathing difficult due to airflow obstruction, with common symptoms including a chronic cough, wheezing, and shortness of breath), hypertension (HTN-high blood pressure), and cataract (the clouding of the eye's natural lens, which causes blurry or faded vision).</p> <p>During a review of Resident 76's History and Physical (H&amp;P), dated 11/30/2025, the H&amp;P indicated Resident 76 has the capacity to understand and make decisions.</p> <p>During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76's cognition (the brain's ability to learn, think, understand and solve problems) was intact.</p> <p>During a review of Resident 76's Care Plan (CP) titled Smoking/Tobacco Use, last updated on 11/02/2025, the CP indicated Resident 76 is at risk for injury accident due to smoking with the goal of Resident 76 will remain free of smoking related injuries /accidents.</p> <p>The CP indicated the following interventions:</p> <ul style="list-style-type: none"> <li>-Assess physical and cognitive abilities to determine the type of assistance to be provided when smoking.</li> <li>-Educate regarding risks of smoking.</li> <li>-Educate regarding alternatives to smoking and refer to support services, as needed.</li> <li>-Educate regarding risks being unsupervised during smoking.</li> <li>-Instruct and encourage compliance with Smoking Schedule.</li> <li>-Educate regarding safe disposal of cigarette butts.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Notify Physician, Family/Responsible party of any injuries resulting from smoking</p> <p>During a concurrent interview and record review of Resident 76's Interdisciplinary Team (IDT - a group of disciplines such as nursing, physician, and social services who meet with a resident or their responsible party to discuss interventions for their medical plan of care) Conference note dated 10/27/2025 with RN 1 on 12/02/2025 at 8:15 A.M., RN 1 stated the IDT note indicated a care plan will be developed based on the level of supervision the resident requires.</p> <p>During a concurrent interview and record review of Resident 76's care plan titled Smoking dated 11/02/2025 with RN 1 on 12/02/2025 at 8:17 A.M., RN 1 stated that Resident 76's care plan is not resident-centered and does not specify the level of supervision the resident requires. RN 1 stated this lack of clarity may result in staff being unaware of the appropriate interventions needed to ensure Resident 85's safety during smoking activities, such as whether the resident requires supervision while smoking, and with or without the use of apron.</p> <p>During an interview on 12/04/2025 at 12:55 P.M. with DON, the DON stated Resident 76's care plan was not resident centered because it lacked interventions addressing the level of supervision the resident requires. The DON stated it is important to address the level of supervision the resident require to ensure staff are aware of the necessary interventions to prevent accidents and hazards during smoking activities.</p> <p>During a review of facility P&amp;P titled Smoking Policy, reviewed on 5/2025, the P&amp;P indicated a plan of care will be developed to addresses each resident's need and level of supervision. A care plan will be developed to address each resident's needs and level of supervision. Based on the safety assessment residents will be categorized as either safe to smoke without supervision (no smoking apron needed) Require supervision while smoking for safety with or without smoking aprons.</p> <p>During a review of facility P&amp;P titled Comprehensive Care Plan, reviewed on 5/2025, the P&amp;P indicated it is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment .</p> <p>1.b. During a review of Resident 85's admission Record, the admission Record indicated the facility admitted Resident 85 on 4/10/2024 with diagnoses including hemiplegia (paralysis affecting one side of the body), HTN, and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 85's H&amp;P, dated 9/25/2025, the H&amp;P indicated Resident 85 can make needs known but cannot make medical decisions.</p> <p>During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 cognition was intact.</p> <p>During a review of Resident 85's Care Plan updated on 10/25/2025 titled Smoking/Tobacco Use indicated Resident 85 is at risk for injury accident due to smoking with the goal of Resident 85 will remain free of smoking related injuries /accidents.</p> <p>The CP indicated the following interventions:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>-Assess physical and cognitive abilities to determine the type of assistance to be provided when smoking</li> <li>-Educate regarding risks of smoking.</li> <li>-Educate regarding alternatives to smoking and refer to support services, as needed.</li> <li>-Educate regarding risks being unsupervised during smoking.</li> <li>- Instruct and encourage compliance with Smoking Schedule.</li> <li>-Educate regarding safe disposal of cigarette butts.</li> <li>-Notify Physician, Family/Responsible party of any injuries resulting from smoking.</li> </ul> <p>During a concurrent interview and record review of Resident 85's IDT note dated, 10/27/2025 and care plan titled Smoking/Tobacco use dated 10/29/2025 with RN 1 on 12/02/2025 at 8:25 A.M., RN 1 stated IDT note indicated a care plan will be developed based on the level of supervision the resident requires.</p> <p>During an interview and record review of Resident 85 care plan titled Smoking/Tobacco use dated 10/29/2025 with RN 1 on 12/02/2025 at 8:27 A.M., RN 1 stated that Resident 85's care plan is not resident-centered and does not specify the level of supervision the resident requires. This lack of clarity may result in staff being unaware of the appropriate interventions needed to ensure Resident 85's safety during smoking activities, such as whether the resident requires supervision while smoking, and with or without the use of apron.</p> <p>During an interview on 12/04/2025 at 12:55 P.M. with DON, the DON stated Resident 85's care plan was not resident centered because it lacked interventions addressing the level of supervision the resident requires. The DON stated it is important to address the level of supervision the resident requires to ensure staff are aware of the necessary interventions to prevent accidents and hazards during smoking activities.</p> <p>During a review of facility P&amp;P titled Smoking Policy, reviewed on 5/2025, the P&amp;P indicated a plan of care will be developed to addresses each resident's need and level of supervision. A care plan will be developed to address each resident's needs and level of supervision. Based on the safety assessment residents will be categorized as either safe to smoke without supervision (no smoking apron needed) Require supervision while smoking for safety with or without smoking aprons.</p> <p>During a review of facility P&amp;P titled Comprehensive Care Plan, reviewed on 5/2025, the P&amp;P indicated it is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 81's admission Record, the admission Record indicated the facility originally admitted the resident on 5/12/2022 and readmitted the resident on 8/20/2025 with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood) and an anxiety disorder (a mental health condition that causes excessive fear, worry, and feelings of dread and uneasiness).</p> <p>During a review of Resident 81's H&amp;P dated 8/20/2025, the H&amp;P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 81's MDS, dated [DATE], the MDS indicated the resident had severe cognitive impairment (trouble with thinking, learning, and remembering clearly) and was dependent on staff or needed substantial assistance with most ADLs. The MDS further indicated Resident 81 was on an antianxiety medication.</p> <p>During a review of Resident 81's Order Summary Report, the Order Summary Report indicated an order, dated 8/20/2025, to administer one 0.5 milligram tablet of Klonopin two times per day for anxiety.</p> <p>During a concurrent interview and record review on 12/3/2025 at 11:48 a.m. with Registered Nurse (RN) 1, Resident 81's care plan titled Psychotropic Medication Black Box Warning Medications, dated 8/22/2025, and .at risk for adverse reaction related to use of antianxiety medication(s)., dated 8/21/2025, were reviewed. The care plan Psychotropic Medication Black Box Warning Medications did not indicate the resident was on Klonopin or the black box warning for it. The care plan .at risk for adverse reaction related to use of antianxiety medication(s)., did not indicate there was a black box warning for Klonopin. RN 1 stated these care plans were not specific to the black box warnings of Klonopin. RN 1 stated without a care plan for the black box warnings they would be able to monitor for those side effects.</p> <p>During a concurrent interview and record review on 12/4/2025 at 1:58 p.m. with the DON, the black box warning for Klonopin and Resident 81's care plans titled Psychotropic Medication Black Box Warning Medications, dated 8/22/2025, and .at risk for adverse reaction related to use of antianxiety medication(s)., dated 8/21/2025, were reviewed. The DON stated Resident 81's care plan should be updated to include the black box warning for Klonopin. The DON stated the black box warning indicated there is a risk of abuse, addiction, dependence, and withdrawal reactions from Klonopin and these should be included in the care plan so they can monitor for them, and staff will know the dangers of the medication.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&amp;P titled, Comprehensive Care Plan, last reviewed 5/14/2025, the P&amp;P indicated it is the facility's policy that a comprehensive resident-centered care plan be developed for each resident which includes measurable objectives and timeframes to meet each resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The P&amp;P indicated a comprehensive care plan will be completed within seven days after the completion of the resident's MDS.</p>

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NAME OF PROVIDER OR SUPPLIER  Sunland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  8647 Fenwick Street. Sunland, CA 91040	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to Involve the resident's representative or responsible party (RP) during the Interdisciplinary (IDT- a collaborative approach where healthcare professionals from various disciplines work together to provide comprehensive patient care) Care Plan (a structured document that outlines a patient's healthcare needs, goals, and the nursing interventions required to achieve those goals) meeting (quarterly and annually) for one of seven residents (Resident 47) reviewed under the accidents care area. This deficient practice had the potential to result in Resident 47 receiving inadequate care and supervision at the facility. Findings: During a review of Resident 47's admission Record, the admission Record indicated the facility admitted the resident to the facility on 5/14/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) following stroke (loss of blood flow to a part of the brain) affecting the left side, and aphasia (a disorder that makes it difficult to speak). During a review of Resident 47's Minimum Data Set (MDS, a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 47 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 47 was able to walk 10 feet in the hallway with partial assistance (helper does less than half the effort). The MDS indicated Resident 47 has not exhibited wandering behavior. During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 47 was able to walk 150 feet in the hallway with supervision or touching assistance (helper provides verbal cues and/or touching/steadying as resident completes the activity). During a review of Resident 47's History and Physical (H&amp;P), dated 5/17/2025, the H&amp;P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 47's Interdisciplinary Team (a group of disciplines such as nursing, physician, and social services who meet with a resident or their responsible party to discuss interventions for their medical plan of care) Care Plan Conference Summary, dated 5/15/2025, the IDT meeting indicated Resident 47 does not have any emergency contacts. During a review of Resident 47's IDT Care Plan Conference Summary, dated 8/25/2025, the IDT Care Plan Conference Summary indicated Resident 47's responsible party was contacted for the IDT meeting but had not returned the phone call and were not at the care plan meeting. During a concurrent interview and record review with Registered Nurse 1 on 12/03/2025 at 3:30 p.m., Resident 47's IDT Care Conference dated 8/25/2025 was reviewed. RN 1 stated the facility should have followed up the phone call with another one to ensure Resident 47's family was involved in the resident's care. During an interview with the Director of Nurses (DON) on 12/04/2025 at 12:36 p.m., the DON reviewed Resident 47's IDT Care Plan Conference Summary, dated 8/25/2025, which indicated a voicemail was left with the former responsible party (FRP) on 8/20/2025 and was waiting for callback. The DON stated according to the IDT Care Plan Conference Summary, neither Resident 47's responsible party nor former responsible party were present for Resident 47's IDT Care Conference on 8/25/2025. The DON stated the facility should have followed up the phone call with another one. The DON stated this is important to ensure Resident 47's family is involved in the resident's care. During a review of the facility's policy and procedure (P&amp;P) titled, Care Planning - IDT, last reviewed on 5/14/2025, the P&amp;P indicated the following: -The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development and revisions to the resident centered care plan -Every effort will be made to schedule care plan meetings at the best time of the day for the resident and the resident's family.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review the facility failed to ensure residents receive care in accordance with professional standards of practice by failing to rotate insulin injection sites to one of two residents (Resident 6) reviewed under the insulin care area. The deficient practice had the potential for adverse effect (unwanted, unintended result) of same site subcutaneous administration of insulin such as lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (a rare disease that occurs when a protein called amyloid builds up in organs) to Resident 6. Findings: During a review of Resident 6's admission Record, the admission Record indicated the facility originally admitted Resident 6 on 5/13/2025 and readmitted the resident on 7/13/2025 with diagnoses including type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness and chronic obstructive pulmonary disease (COPD-a progressive lung condition causing difficulty in breathing). During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/18/2025, the MDS indicated the resident's cognitive skills (cognition refers to conscious mental activities, and include thinking, reasoning, understanding, learning, and remembering) for daily decision making was intact. The MDS indicated Resident 6 required assistance in performing activities of daily living (are basic routine tasks like eating, dressing, bathing, and toileting, necessary for independent self-care). During a review of Resident 6's Order Summary Report, the Order Summary Report indicated an order dated 7/13/2025 for Insulin Aspart Injection Solution 100 units per milliliters (Unit/ml, a unit of fluid volume), inject per sliding scale: If 150-199 mg/dl= 1 unit; 200-249 mg/dl= 2 units; 250-299 mg/dl= 3 units; 300-349 mg/dl= 4 units; greater than 349 mg/dl= 5 units, subcutaneously before meals and at bedtime for diabetes; less than 100 mg/dl= 0 units and inform physician. During an interview and record review on 12/02/2025 at 9:46 a.m., with Registered Nurse 2 (RN 2) reviewed Resident 6's Insulin Aspart Injection administration in the Medication Administration Record (MAR). The MAR indicated the following date and time of administration and injection site location: 10/02/2025 at 09:38 p.m., abdomen - left lower quadrant (LLQ) 10/03/2025 at 09:52 p.m., abdomen - left lower quadrant (LLQ) 10/04/2025 at 09:43 p.m., abdomen - left lower quadrant (LLQ) 10/07/2025 at 12:23 p.m., abdomen - left lower quadrant (LLQ) 10/08/2025 at 08:28 p.m., abdomen - left lower quadrant (LLQ) 10/10/2025 at 08:28 p.m., abdomen - left lower quadrant (LLQ) 10/16/2025 at 05:03 p.m., abdomen - left lower quadrant (LLQ) 10/16/2025 at 09:44 p.m., abdomen - left lower quadrant (LLQ) 10/18/2025 at 09:07 p.m., abdomen - left lower quadrant (LLQ) 10/20/2025 at 09:44 p.m., abdomen - left lower quadrant (LLQ) 10/21/2025 at 09:49 p.m., abdomen - left lower quadrant (LLQ) 10/22/2025 at 09:56 p.m., abdomen - left lower quadrant (LLQ) 10/26/2025 at 09:30 p.m., abdomen - left lower quadrant (LLQ) 10/27/2025 at 09:25 p.m., abdomen - left lower quadrant (LLQ) 10/28/2025 at 09:49 p.m., abdomen - left lower quadrant (LLQ) RN 2 stated that insulin injection sites should be rotated to prevent injury. RN 2 stated repeated insulin injections at the same site can cause the resident pain. During a review of the facility's policy and procedures (P&amp;P) titled Insulin Administration, last reviewed on 5/14/2025, the P&amp;P indicated that injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility's P&amp;P titled Medication Administration, last reviewed on 5/14/2025, the policy indicated that It is the policy of the facility that medications for residents be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the physician orders, including any required time frame.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to provide an environment that is free from accident hazards to four of eight sampled residents (Resident 12, 61, 76 and 85) by failing to: 1. Ensure Resident 12's fall risk assessment was accurate to reflect Resident 12's risk of falling. 2. Ensure disinfectant wipes container was not left open, unattended and within reach at the top of Resident 61's tray table. 3. Ensure Resident 76 and 85 did not possess a lighter and cigarette as indicated in the facility policy titled, Smoking Policy. 4. Ensure Resident 76 and 85's The Safe Smoking Evaluation specify whether both residents were independent smokers or supervised smokers, as indicated in the facility policy titled, Smoking Policy. These deficient practices had the potential to increase Resident 12's risk of falling, potential to result in accidental poisoning if disinfectant wipes were ingested by Resident 61 and potential to result in an accidental fire in the facility that can lead to injury to the residents. Findings:</p> <p>1. During a review of Resident 12's admission Record, the admission Record indicated the facility originally admitted the resident on 9/9/2019 and readmitted the resident on 10/26/2025 with diagnoses including, but not limited to, acute respiratory failure (a condition where the lungs cannot release enough oxygen into the blood), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought), and generalized muscle weakness.</p> <p>During a review of Resident 12's History and Physical (H&amp;P) dated 10/28/2025, the H&amp;P indicated the resident had the capacity to understand and make decisions.</p> <p>During a review of Resident 12's Minimum Data Set (MDS &amp;ndash; a resident assessment tool), dated 10/30/2025, the MDS indicated the resident was cognitively intact (able to think, learn, and remember clearly) and needed substantial assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).</p> <p>During a concurrent interview and record review on 12/3/2025 at 11:48 a.m. with Registered Nurse (RN) 1, Resident 12's MDS, dated [DATE], indicated Resident 12 had one fall since the previous assessment and Resident 12's Fall Risk Evaluation, dated 10/26/2025, indicated the resident had no falls within the past three months. RN 1 stated she could not find information in the resident's current chart about the fall.</p> <p>During a concurrent interview and record review on 12/3/2025 at 3:31 p.m. with the Assistant Director of Nursing (ADON), Resident 12's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 9/10/2025, indicated Resident 12 reported she fell on 9/10/2025 and had new pain to her right foot. Resident 12's Fall Risk Evaluation, dated 10/26/2025, indicated Resident 12 had not fallen in the last three months. The ADON stated the Fall Risk Evaluation should indicate that the resident had a fall. The ADON stated with an accurate Fall Risk Evaluation the staff would know the resident is at a higher risk for falls and they might change what interventions they provide by including her in their Fall Star Program (a patient safety initiative to identify residents who are at a high risk of falls and implement extra precautions).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 12/4/2025 at 1:58 p.m. with the Director of Nursing (DON), the DON stated Resident 12's Fall Risk Evaluation, dated 10/26/2025, was incorrect. The DON stated Resident 12's Fall Risk Evaluation should be accurate so that staff is aware Resident 12 is at risk for falling and that she had a previous fall. The DON stated if staff members are not aware of Resident 12's risk for falling it places her at a higher risk for having another fall incident.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Fall Risk &amp; Prevention of Injury to Include Pathological Fractures, last reviewed 5/14/2025, the P&amp;P indicated it is the policy of the facility to identify residents that are at risk for falls and to implement a plan of care in an attempt to prevent falls.</p> <p>During a review of the facility's P&amp;P titled, Falling Star Program, last reviewed 5/14/2025, the P&amp;P indicated the purpose of the policy is to identify residents who are at risk for falls, to try to prevent falls, and to attempt to increase supervision for residents assessed to be at high risk for falls.</p> <p>2. During a review of Resident 61's, the admission Record indicated the facility originally admitted Resident 61 on 1/20/2022 and readmitted the resident on 3/4/2024 with diagnoses including paroxysmal atrial fibrillation (an irregular rapid heart rate that commonly causes poor blood flow), chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe) and generalized muscle weakness.</p> <p>During review of Resident 61's MDS, dated [DATE], MDS indicated Resident 61 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and mostly supervision assistance needed from staff for ADLs.</p> <p>During a concurrent observation and interview on 12/1/2025 at 9:58 a.m., with Registered Nurse 2 (RN 2), in Resident 61's room, observed an opened disinfectant wipe container on top of Resident 61's tray table next to the breakfast tray. RN 2 stated Resident 61's tray table has an opened disinfectant wipes container that was left unattended and within reach by Resident 61. RN 2 also stated that it was not safe for Resident 61 to have any type of chemical due to safety concerns. RN 2 also stated that if a resident wanted to clean or disinfect something, the staff should do it for them.</p> <p>During an interview on 12/4/2025 at 8:28 a.m., with the DON, the DON stated that due to resident safety, residents should not be provided with any disinfectant wipes for possible ingestion of the toxic chemicals found in the disinfectant wipes.</p> <p>During a review of facility's P&amp;P, titled, Safety and Supervision of Residents, reviewed on 5/14/2025, the P&amp;P indicated, It is the policy of the facility to make the environment as free from accident hazards as possible. Resident safety, supervision and assistance to prevent accidents are facility-wide priorities.</p> <p>During a review of facility's P&amp;P, titled, Facility Guidelines, reviewed on 5/14/2025, the P&amp;P indicated, Residents are not permitted to have any flammable or unsafe chemicals at the bedside, i.e., nail polish, air freshener, laundry chemicals, etc. or any items that specifies, 'keep out of the reach of children'.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3a. During a review of Resident 76's admission Record, the admission Record indicated the facility admitted Resident 76 on 4/27/23 with diagnoses including COPD, hypertension (HTN-high blood pressure), and cataract (the clouding of the eye's natural lens, which causes blurry or faded vision).</p> <p>During a review of Resident 76's H&amp;P, dated 11/30/25, the H&amp;P indicated Resident 76 has the capacity to understand and make decisions.</p> <p>During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 cognition (refers to mental abilities and processes) was intact.</p> <p>During a review of Resident 76's Smoker's Risk Assessment, dated 10/29/25, the Smoker's Risk Assessment indicated Resident 76 may smoke independently or with set up, must be supervised and may not smoke unsupervised.</p> <p>During a review of Resident 76's Smoking Behavior Contract, dated 10/27/25, the Smoking Behavior Contract indicated that if Resident 76 disregard smoking safety regulations, it will jeopardize his ability to remain at the healthcare residence.</p> <p>During a review of Resident 76's Interdisciplinary Team Conference (IDT - a group of disciplines such as nursing, physician, and social services who meet with a resident or their responsible party to discuss interventions for their medical plan of care) note, dated 10/27/25, the IDT note indicated, residents are not permitted to have cigarettes and lighters, facility shall store smoking materials in locked areas. the resident room will be monitored by a designee to determine that no smoking material are in the possession of the resident or in their room. if residents are found to have any smoking materials, they will remove and interdisciplinary team meeting will be scheduled with the residents. A care plan will be develop based on level of supervisor.resident will be categorized as either safe to smoke without supervisor -no smoking apron needed or require supervisor while smoking safety with or without a smoking apron.</p> <p>During an interview on 12/1/2025 at 3:38 p.m. with Certified Nursing Assistant 7 (CNA 7), CNA 7 stated he observed Resident 76 at around 10 a.m. today (12/1/2025) in possession of a lighter and cigarettes. CNA 7 stated when he tried to collect them from Resident 76, the resident refused and became agitated. CNA 7 stated he reported the incident to the Activity Director (AD).</p> <p>During an interview with the AD on 12/01/2025 at 3:46 PM, the AD stated that based on facility policy residents are not allowed to carry their lighters or cigarettes with them due to fire danger. The AD stated activity staff keep the lighter and cigarettes in a locked cabinet and during designated smoking times, the cigarettes and lighter are handed to the residents and are collected afterward and returned to the locked cabinet. The AD stated it is her responsibility to ensure residents do not carry smoking materials. The AD stated she was not informed that Resident 76 possesses cigarette and a lighter.</p> <p>During an interview on 12/02/2025 at 8:06 A.M., with RN 1, RN 1 stated residents are not allowed to have lighters and cigarettes with them due to safety issues and the potential for accidents and fire hazard.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview and record review of Resident 76 Safe smoking evaluation dated 10/29/2025 with RN 1 on 12/02/2025 at 8:10 a.m., RN 1 stated she was the one who completed the safe smoking evaluation/assessment form for Resident 76. RN 1 stated based on facility policy the smoker should be identified as either independent smoker or supervised. However, the smoking assessment indicated Resident 76 may smoke independently, must be supervised and also may not smoke unsupervised. RN 1 stated the evaluation did not specifically indicate if Resident 76 is independent or supervised, and it is confusing. RN 1 stated the potential outcome of not having accurate assessment is staff will not know what interventions Resident 76 needs.</p> <p>3b. During a review of Resident 85's admission Record, the admission Record indicated the facility initially admitted Resident 85 on 4/10/2024 with diagnoses including hemiplegia (paralysis affecting one side of the body), HTN, and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 85's H&amp;P, dated 9/25/25, the H&amp;P indicated Resident 85 can make needs known but cannot make medical decisions.</p> <p>During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85's cognition was intact.</p> <p>During a review of Resident 85's Smoker's Risk Assessment, dated 10/29/25, the Smoker's Risk Assessment indicated Resident 85 may smoke independently or with set up, must be supervised and may not smoke unsupervised. Resident 85 must request smoking material from staff.</p> <p>During a review of Resident 85's Smoking Behavior Contract, dated 10/27/25, the Smoking Behavior Contract indicated, if Resident 85 disregards smoking safety regulations, it will jeopardize his ability to remain at the healthcare residence.</p> <p>During a review of Resident 85's IDT note, dated 10/27/25, the IDT note indicated, residents are not permitted to have cigarettes and lighters. facility shall store smoking materials in locked areas. the Resident room will be monitored by a designee to determine that no smoking material are in the possession of the resident or in their room. if Residents are found to have any smoking materials, they will remove, and interdisciplinary team meeting will be scheduled with the residents. A care plan will be developed based on level of supervision. resident will be categorized as either safe to smoke without supervisor, no smoking apron needed or require supervisor while smoking safety with or without a smoking apron.</p> <p>During a concurrent observation and interview on 12/01/2025 at 3:42 p.m., in the smoking patio, with Resident 85, in the presence of the AD, observed Resident 85 wheeling himself to the smoking patio. Resident 85 removed a lighter and cigarette from his cross-body bag and light his cigarette. Resident 85 stated that the lighter and cigarettes in his possession belong to him and that he has kept them with him at all times for more than two weeks now.</p> <p>During an interview on 12/02/2025 at 8:06 A.M., with RN1, RN 1 stated residents are not allowed to have lighters and cigarettes with them due to their safety issues potential for accident and fire hazard.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review of Resident 85 Safe smoking evaluation dated 10/29/2025 with RN 1 on 12/02/2025 at 8:20 a.m., RN 1 stated she was the one who completed the safe smoking evaluation/assessment form for Resident 85. RN 1 stated based on facility policy the smoker should be identified as either independent smoker or supervised. However, the smoking assessment indicated Resident 85 may smoke independently, must be supervised and also may not smoke unsupervised. RN 1 stated the evaluation did not specifically indicate if Resident 85 is independent or supervised, and it is confusing. RN 1 stated the potential outcome of not having accurate assessment is staff will not know what interventions Resident 85 needs.</p> <p>During an interview on 12/04/2025 at 10:06 A.M. with the Administrator (ADM), the ADM stated based on facility policy, residents are not permitted to carry or possess lighters or cigarettes while in the facility. This rule is in place to ensure the safety of all residents, staff, and the facility, particularly due to the presence of oxygen use, which poses a serious fire and explosion risk when exposed to open flames. The Administrator stated all smoking materials must be stored in a locked cabinet. The ADM stated he collected the lighters and cigarettes from Resident 75 and Resident 85 on 12/01/2025.</p> <p>During an interview on 12/04/2025 at 11:50 A.M. with DON, the DON stated Residents are not permitted to possess lighters or cigarettes while in the facility to ensure the safety of all individuals particularly those who use oxygen, which poses a serious risk of explosion when exposed to open flames. The DON stated all smoking materials must be stored in a locked cabinet and if staff witness a resident carry a lighter or cigarette they should report it to the AD, the ADM or the DON. The DON stated that based on facility smoking policy, residents are categorized as either supervised or independent smokers. However, the smoking assessments for Resident 76 and Resident 85 do not clearly specify their supervision status. The DON stated that this lack of clarity may lead to confusion among staff regarding appropriate safety interventions such as whether a resident requires a smoking apron or is permitted to smoke independently potentially compromising safe smoking practices.</p> <p>During a review of facility P&amp;P, titled Smoking Policy, reviewed May 2025, indicated a smoking policy has been implemented to promote resident safety and protect residents' rights and dignity. All smoking materials such as cigarettes, lighters and smoking aprons will be stored in locked areas. Through the assessments process, smokers are designated as either independent or supervised smokers.</p> <p>-An independent smoker is defined as the one who use all smoking material in a safe and responsible manner. Can state smoking rules and designated smoking area. Observes all smoking rules and adhere to facility policy.</p> <p>-A supervised smoker defines as demonstrate unsafe behavior in the use of smoking and/or lighting materials. Cannot state rules.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to provide appropriate care and services to maintain acceptable parameters of nutritional status for one of four sampled residents (Resident 9) reviewed under the nutrition care area by failing to notify the kitchen staff of the new physician's order for a large portion breakfast for Resident 9. This deficient practice had the potential to place Resident 9 at risk for weight loss. Findings: During a review of Resident 9's admission Record (face sheet), the admission Record indicated that the facility originally admitted the resident on 2/23/2022 and readmitted the resident on 4/30/2025, with diagnoses including dysphagia (swallowing difficulties), unspecified psychosis ( a collection of symptoms that affect the mind, where there has been some loss of contact with reality) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool) dated 10/31/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 9 was totally dependent on staff for self-care. The MDS further indicated that Resident 9 did not have a weight loss in the last three months. During a review of Resident 9's Physician Order Summary Report, the Order Summary Report indicated an order dated 10/28/2025, to add large portion at breakfast. During a review of Resident 9's Nutritional Status Care Plan (written guide that organizes information about the resident's care) initiated on 5/11/2025 and last revised on 11/25/2025, the care plan indicated a goal that the resident's nutritional needs will be adequately met as manifested by having no significant weight changes within 90 days. The care plan interventions included to provide diet as ordered. During a concurrent interview and record review on 12/02/2025 at 12:10 p.m., with the Kitchen Supervisor (KS), reviewed Resident 9's meal tray card (a card placed on a resident's meal tray that lists important dietary information including portion sizes). The KS stated the meal tray card did not indicate the order for a large portion breakfast; it instead indicated a regular portion. The KS stated that when a physician orders a dietary modification such as increase in portion for a certain meal or there is a change in resident's food preferences, the nursing department would communicate the orders to the kitchen by submitting a ticket. The KS stated that they have not received a ticket from the nursing department that indicated the physician ordered a large portion for breakfast. During a concurrent interview and record review on 12/02/2025 at 2:48 p.m., with the Registered Dietitian (RD- a health professional who has special training in diet and nutrition) reviewed Resident 9's dietary recommendation. The RD stated that she assessed the nutritional needs of Resident 9 and established an ideal body weight of 154 pounds (lbs.) The RD stated that she had recommended adding a large portion for breakfast on 10/28/2025 which was then approved by the physician who wrote the order on the same day. The RD stated that upon receipt of the physician's dietary order, the nursing staff will then write a ticket to be endorsed to the kitchen staff for implementation. During an interview on 12/02/2025 at 3:34 p.m., with the Director of Nursing (DON), the DON stated that when there is an RD recommendation, licensed nurses will communicate the RD's recommendation to the physician and obtain the order once the physician approves the recommendation. The DON stated that upon receipt of the diet order, the licensed nurse will then write a ticket to the kitchen staff indicating the diet order to be implemented. The DON stated if the diet order is not communicated timely to the kitchen staff, it can potentially affect the resident's health, including causing a calorie deficit that may result in delayed wound healing and malnutrition. During a concurrent interview and record review on 12/03/2025 at 1:36 p.m., with Registered Nurse 2 (RN 2), Resident 9's current diet order was reviewed. RN 2 stated that there was an order on 10/28/2025 for a large portion breakfast which was not carried out until today (12/3/2025). RN 2 stated that the licensed nurse who received the order from the physician should have communicated the order to the kitchen staff for implementation. RN 2 stated that when a physician's order is not carried out, it can result in unmet nutritional needs, leading to weight loss and other health complications. During a review of the facility's policy and procedures (P&amp;P) titled Activities of Daily Living, Quality of Care, Routine Resident Monitoring, and Scope of Services, last reviewed on 5/14/2025, the P&amp;P indicated that It is the policy of the facility that each resident receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being consistent with the resident's comprehensive assessment and plan of care. This will include that nursing staff conduct routine resident monitoring to ensure resident safety and well-being. Staff will ensure that Activities of Daily Living are</p>		

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NAME OF PROVIDER OR SUPPLIER  Sunland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  8647 Fenwick Street. Sunland, CA 91040	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview and record review, the facility failed to provide necessary respiratory care consistent with professional standards of practice for one of one resident (Resident 91) reviewed under respiratory care area by failing to ensure Resident 91 received oxygen as ordered by the physician. This deficient practice had the potential to cause Resident 91 shortness of breath that could lead to hypoxemia (a low level of oxygen in the blood. Findings: During a review of Resident 91's admission Record (AR), the admission Record indicated the facility admitted Resident 91 to the facility on 9/20/2023 and readmitted the resident on 3/8/2025 with diagnoses including respiratory failure (condition in which your blood does not get enough oxygen or has too much carbon dioxide), diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]) and obesity(a disorder involving excessive body fat that increases the risk of health problems). During review of Resident 91's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 9/24/2025, the MDS indicated Resident 91 has intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and moderate to dependent from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). MDS also indicated Resident 91 was receiving oxygen therapy. During a concurrent observation, interview and record review on 12/1/2025 at 10:25 a.m., with the Director of Staff Development (DSD), in Resident 91's room, observed Resident 91's oxygen rate was at 1.5 liters per minute (LPM). Resident 91's Order Summary Report (OSR) indicated an order dated 9/20/2025 for continuous oxygen at 2-4 LPM every shift. The DSD stated that Resident 91 should have an oxygen rate of 2-4 LPM, not 1.5 LPM. The DSD stated the resident has a possible risk of desaturation (low blood oxygen) and the physician's order should have been followed. During an interview on 12/4/2025 at 8:28 a.m., with the Director of Nursing (DON), the DON stated that licensed nurses should follow the physician's order to ensure Resident 91 is receiving the prescribed oxygen flow rate. During a review of facility's policy and procedure (P&amp;P), titled, Medication Administration, reviewed on 5/14/2025, the P&amp;P indicated, It is the policy of the facility that medications for residents be administered in a safe, and timely manner and as prescribed.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to: Reconcile (the process of comparing transactions and activity to supporting documentation) and account for five (5) medication emergency kits (eKITS) containing Controlled Medications ([CM] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Drugs or Controlled Substances {CS}) for November and December 2025, in three (3) of three (3) inspected Medication Rooms (Medication Room Station 1, Station 2 and Station 3/4) and one (1) of two (2) inspected medication carts (Medication Cart Station 4.) 2. Account for two (2) doses of lacosamide (a CM used for seizure [bursts of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle movements, behaviors, sensations, or states of awareness]) for Resident 54 in two (2) of two (2) inspected medication carts (Medication Cart Station 2 and 4.) As a result, control and accountability of medications and CM's did not follow state and federal regulations and facility policy and procedures These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that Resident 54 and other residents in the facility could have accidental overdose (administering more than the prescribed dose causing adverse drug reactions [unwanted, uncomfortable, or dangerous effects that a medication may have, such as coma (a state of deep unconsciousness) from exposure to harmful medications, and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization. Findings: During an observation on 12/1/2025 at 2 p.m., with Licensed Vocational Nurse (LVN) 5, in Medication Cart Station 4, there was: 1.a discrepancy in the count between the Antibiotic or Controlled Drug Record and the amount of medication remaining in the medication bubble pack (a medication packaging system that contains individual doses of medication per bubble) for Resident 54. One (1) dose of lacosamide 200 milligram ([mg] - a unit of measure of mass) tablet was missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 54. The Antibiotic or Controlled Drug Record accountability log for lacosamide indicated the medication bubble pack should have contained a total of 17 lacosamide 200 mg tablets, after the last administration of lacosamide 200 mg tablet documented/signed-off on 11/30/2025 at 5 p.m., however the medication bubble pack contained 16 lacosamide 200 mg tablet and contained no other documentation of subsequent administrations. 2.One (1) medication eKIT labeled 125, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for November and December 2025. During a concurrent interview, LVN 5 stated LVN 5 administered 200 mg tablet to Resident 54 earlier that day at 9 a.m. and forgot to sign off the Antibiotic or Controlled Drug Record accountability log. LVN 5 stated LVN 5 failed to follow the facility's policy of signing each CM dose on the Antibiotic or Controlled Drug Record accountability log after preparing the doses for the residents. LVN 5 stated LVN 5 understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 5 stated if documentation was not accurate then it can lead to overdose harming Residents 54 leading to respiratory depression (stoppage of breathing) and potential hospitalization. During the same interview, LVN 5 stated that all CMs, including medication eKITS containing CMs should be reconciled at every shift. LVN 5 stated the eKIT labeled 125 containing CMs in Medication Cart Station 4 was not reconciled at every shift for November and December, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During an observation on 12/2/2025 at 9:42 a.m., with Registered Nurse (RN) 2, in Medication Room Station 3/4 there were: -Two (2) medication eKITS stored in the refrigerator and labeled 100 and 601, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for November and December 2025. During a concurrent interview, RN 2 stated that all CMs, including medication eKITS containing CMs should be reconciled at every shift. RN 2 stated that two (2) eKITS labeled 100 and 601 containing CMs in Medication Room Station 3/4 were not reconciled at every shift in November and December 2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During an observation on 12/2/2025 at 10:05 a. m., with the Assistant Director of Nursing (ADON,) in Medication Room Station 2 there was: -One (1) medication eKIT stored in the refrigerator and labeled 301 containing CMs without an accountability log for</p>		

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NAME OF PROVIDER OR SUPPLIER  Sunland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  8647 Fenwick Street. Sunland, CA 91040	

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Three (3) medication errors out of 25 total opportunities contributed to an overall medication error rate of 12% affecting three (3) of five (5) residents observed for medication administration (Resident 37, 70, and 101.) The medication errors were as follows: Resident 37 received aspirin (a medication used for cerebrovascular accidents ([CVA] - an interruption in the flow of blood to cells in the brain) by thinning the blood,) prophylaxis ([PPX] - action taken to prevent disease,) at a different time than ordered by Resident 37's physician. 2. Resident 70 received a form of multivitamin (a medication used as dietary supplement to provide vitamins, minerals, and other nutritional elements as tolerated) that was different than the one ordered by Resident 70's physician. 3. Resident 101 received carvedilol (a medication used to for hypertension [HTN - a condition in which the blood vessels have persistently raised pressure]) at a different time than ordered by Resident 101's physician. These failures had the potential to result in Resident 37, 70, and 101 receiving suboptimal (less than standard) care, experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and resulting in Residents 37, 70, and 101 health and well-being negatively impacted. Findings: During an observation on 12/1/2025 at 9:05 a.m., in Medication Cart Station 3, Licensed Vocational Nurse (LVN) 5 was observed administering carvedilol 6.25 milligram ([mg]-a unit of measure of mass) tablet orally to Resident 101. Resident 101 was observed swallowing the carvedilol tablet with a glass of water. During an observation on 12/1/2025 at 9:30 a. m., in Medication Cart 3, LVN 5 was observed administering aspirin 81 mg chewable tablet to Resident 37. Resident 37 was observed swallowing the aspirin tablet with a glass of juice. During an observation on 12/1/2025 at 10 a.m., in Medication Cart Station 4, Registered Nurse (RN) 4 was observed administering multivitamin with minerals tablet orally to Resident 70. Resident 70 was observed swallowing the multivitamin with mineral tablet with a glass of water. During an interview on 12/1/2025 at 12:05 p.m., with RN 4, RN 4 stated RN 4 administered multivitamin with minerals tablet earlier at 10 a.m. to Resident 70. RN 4 stated RN 4 acknowledged the physician order for Resident 70 indicated to give multivitamin not containing minerals. RN 4 stated RN 4 failed to administer the correct multivitamin as prescribed by Resident 70's physician. RN 4 stated administering multivitamin with minerals to Resident 70 may not be beneficial to their health and may cause adverse effects if unable to process the extra minerals. RN 4 stated this was considered a medication error. During an interview on 12/1/2025 at 12:20 p.m., with LVN 5, LVN 5 stated LVN administered carvedilol 6.25 mg tablet during the morning medication administration at 9:05 a.m. to Resident 101. LVN 5 acknowledged the physician order for Resident 101 specified to administer carvedilol at 7:30 a. m. with breakfast to prevent stomach discomfort. LVN 5 stated Resident 101 had breakfast at 7 a.m. LVN 5 stated per facility policy there was a 60-minute window for medication administration and LVN 5 administered carvedilol later than that timeframe. LVN 5 stated LVN 5 failed to administer carvedilol as prescribed by Resident 101's physician placing Resident 101 at risk of receiving the next dose closer in time and experiencing stomach irritation. LVN 5 stated this was considered a medication error. During the same interview, LVN 5 stated that LVN 5 administered aspirin 81 mg chewable tablet during the morning medication administration at 9:30 a.m. to Resident 37. LVN 5 acknowledged the physician's order to Resident 37 specified to administer aspirin at 7:30 a.m. with food to prevent stomach discomfort. LVN 5 stated Resident 37 had breakfast at 7 a.m. LVN 5 stated that LVN 5 administered the aspirin later than the facility 60-minute window allowance. LVN 5 stated this was also considered a medication error. During an interview 12/2/2025 at 11:15 a.m., with the Director of Nursing (DON), the DON stated LVN 5 failed to administer carvedilol 6.25 mg tablet to Resident 101 and aspirin chewable 81 mg to Resident 37, on 12/1/2025 according to physician orders, at their scheduled time of 7:30 a.m. The DON stated Resident 37 may be at risk for developing stomach irritation from receiving aspirin 81 mg much later , and Resident 101 may be at risk for having the next dose given in a shorter timeframe since it was ordered to be given twice a day, and possible stomach irritation when given much later. The DON stated RN 4 failed to administer multivitamin without minerals to Resident 70, according to physician orders on 12/1/2025. The DON stated Resident 70 may possibly be at risk of not being able to tolerate the additional minerals from the multivitamin with minerals. The DON stated these were considered medication errors. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the</p>		

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NAME OF PROVIDER OR SUPPLIER  Sunland Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  8647 Fenwick Street. Sunland, CA 91040	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to: Record the medication refrigerator temperatures containing vaccines twice a day from [DATE] to [DATE], in one (1) of three (3) inspected medication rooms (Medication Room Station 2.) 2. Remove and discard from use four (4) expired budesonide (a medication used to treat and prevent shortness of breath wheezing [breathing with a whistling sound in the chest] and Chronic Obstructive Pulmonary Disease [COPD]- a disease that blocks air flow and makes breathing difficult) inhalation solutions inside an open foil pouch (package made of foil protecting the inhalation solution from light and degradation) for Resident 54, in accordance with the manufacturer's requirements and facility policy and procedures, in one (1) of two (2) inspected medication carts (Medication Cart Station 2.) These deficient practices increased the potential for Resident 54 to receive suboptimal care resulting in adverse consequences such as exacerbation of COPD leading to breathing difficulty and hospitalization, and for Resident 111 to receive vaccine that was ineffective or toxic due to the inadequate storage monitoring, potentially resulting in negative impact to their health and well-being. Findings: During an observation and concurrent interview on [DATE] at 10:05 a.m., with the Assistant Director of Nursing (ADON), in Medication Room Station 2, the refrigerator contained mResvia (a vaccine used for the prevention of lower respiratory tract disease) vaccine for Resident 111. The refrigerator temperature monitoring log was observed containing documentation for the temperatures once a day [DATE] to [DATE]. The ADON acknowledged the refrigerator contained mResvia vaccine for Resident 111. The ADON noted the refrigerator temperature monitoring form indicated Medication Refrigerator 36-degree Fahrenheit ( F - a unit of measurement) to 46 F. Log Temperature twice daily AM &amp; PM. If the temperature is out of range take corrective action and document. Monitor and maintain temperature per CDC and CDPH guidelines and manufacturer instructions for medication storage requirements for Skilled Nursing Facilities.) The ADON stated between [DATE] to [DATE] the Medication Room Station 2 Medication Refrigerator Temperature Log did not contain documentation for temperature monitoring twice a day. The ADON stated if the temperatures were not documented on the monitoring log, then it was considered that the temperatures were not monitored. ADON stated that several licensed nurses failed to monitor and document the temperature of the refrigerator twice a day between [DATE] to [DATE]. The ADON stated that monitoring the refrigerator temperature was important to ensure medications and vaccines were maintained at the acceptable temperature range (36 and 46 F,) had not gone bad, and their potency (the strength of medication required to produce an effect) was not affected. The ADON stated without monitoring and documenting the temperatures twice a day it was unknown if the refrigerator temperatures were maintained between 36 and 46 F, and if the medications and vaccines were negatively impacted during that time. The ADON stated using improperly maintained vaccine can harm Resident 111 by receiving vaccine that was toxic and ineffective. During an observation on [DATE] at 10:55 a.m., with Licensed Vocational Nurse (LVN) 3, in Medication Cart Station 2, the following medications were found stored in a manner contrary to their respective manufacturers' requirements, expired and not discarded, and contrary to facility policies: One (1) open budesonide inhalation solution foil pouch for Resident 54, was found stored at room temperature and labeled with a date indicating the inhalation solution foil pouch was opened on [DATE]. Four (4) inhalation solutions were observed remaining in the foil pouch. According to the manufacturer's product storage and labeling, the budesonide inhalation solutions should be stored in the foil envelope at room temperature between 68 and 77 degrees Fahrenheit. Once the foil envelope is opened, to use within two (2) weeks. During a concurrent interview, LVN 3 stated the budesonide inhalation solution foil pouch for Resident 54 in the Medication Cart Station 2 was opened on [DATE] and four (4) inhalations were remaining in the foil pouch. LVN 3 stated according to manufacturer guidelines printed on the outside of the budesonide medication box, the inhalation solutions needed to be discarded within two (2) weeks of opening the foil pouch. LVN 3 stated expired budesonide inhalation solutions had lost potency (effectiveness) beyond the expiration date. LVN 3 stated the remaining four (4) inhalation solutions expired on [DATE] and needed to be removed from the medication cart to avoid administering expired and ineffective budesonide to Resident 54. Administering expired budesonide to cause harm to Resident 54 by not treating the shortness of breath and COPD leading to difficulty in breathing, requiring immediate treatment and potential hospitalization. LVN 3 stated several licensed nurses failed to remove expired budesonide inhalation solutions from Medication Cart Station 2 and</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to: 1. Ensure the concentration of the quaternary ammonium sanitizing solution (common, effective chemical used in disinfectants for hard surfaces, killing germs like bacteria or viruses) used to clean kitchen surfaces was maintained at 200 parts per million (ppm- a unit used to express the concentration of a substance in a solution or mixture) to ensure effectiveness of the solution. This failure had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) in food preparation surfaces that could lead to foodborne illnesses (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) for 102 of 108 medically compromised residents who receive food and ice from the kitchen. 2. Ensure food items brought from home were refrigerated or discarded and not left at the bedside for more than 24 hours for one of one sampled resident (Resident 37). This deficient practice had the potential to result in food contamination which could result in foodborne illnesses (also called food poisoning, illness caused by eating contaminated food). Findings: 1. During a concurrent kitchen observation and interview on 12/1/2025 at 7:57 a.m., with [NAME] 1 (CK 1), inspected the kitchen area. CK 1 stated that they use a quaternary ammonium sanitizing solution to clean surfaces including the food preparation area. CK 1 pointed to a red bucket which was filled with the sanitizing solution and stated that they are getting ready to clean and use this sanitizing solution in the red bucket. CK 1 stated that they regularly test the sanitizing solution with a test strip to determine if it has the correct concentration, which is 200 ppm. CK 1 then opened a canister containing test strips and took a test strip out and dipped it into the red bucket filled with the sanitizing solution. CK 1 then compared the color from the test strip with the color guide on the test strip canister to determine the sanitizing solution concentration. Upon comparing the color of the test strip with the color guide from the test strip canister, CK 1 stated that the sanitizing solution concentration is below 100 ppm. CK 1 then discarded the solution from the red bucket and filled it with a fresh sanitizing solution and retested, which again showed that the sanitizing solution concentration was less than 100 ppm. CK 1 stated that she (CK 1) would have to tell her supervisor and will not use the available sanitizing solution. A photo of the test strip showing the color comparison with the color guide from the test strip canister was taken in the presence of CK 1. During an interview on 12/1/2025 at 11:33 a.m., with the Kitchen Supervisor (KS), the KS stated that they maintain a daily log of the quaternary ammonium sanitizing solution concentration to ensure the concentration is at 200 ppm and testing is done every four hours. Upon viewing the photo of the test strip taken earlier with CK 1, the KS confirmed by stating that the sanitizing solution concentration is below 100 ppm. The KS stated that he (KS) will call the supplier to correct the situation. The KS stated that the sanitizing solution will not be effective in disinfecting food preparation surfaces used to chopped vegetables, fruits, and meat, if it is less than 100 ppm. The KS stated that food preparation surfaces can get contaminated and if not disinfected can result in foodborne illnesses. During a review of the facility's policy and procedure titled, Quaternary Ammonium Log Policy, last reviewed on 5/14/2025, the policy indicated, The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution: Procedure: The quaternary solution, used for sanitizing clean work surfaces in the kitchen, will be made according to the instructions on the product container or dispensing device set up for the specific quat product. The Food &amp; Nutrition Services worker will place the solution in the appropriate bucket labeled for its contents and will test the concentration of the sanitation solution. The concentration will be tested at least every shift or when the solution is cloudy. The solution will be replaced when the reading is below 200 ppm. The replacement solution will be tested prior to usage. Food and Nutrition Services staff will record the readings twice a day, once in the AM and once in the PM, document the process was completed. 2. During a review of Resident 37's admission Record, the admission Record indicated the facility originally admitted the resident on 1/12/2024 and readmitted the resident on 2/10/2024 with diagnoses including hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool) dated 10/17/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact. The MDS indicated that Resident 37 required setup or clean-up assistance with activities of daily living (ADLs- fundamental self-care tasks like eating, bathing, dressing, toileting, transferring, and continence care). During a concurrent observation and</p>		

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  12/04/2025
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)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (prevents infection from pneumonia [infection that infects one of both lungs]) was offered to one of seven sampled residents (Resident 58) per the facility's policy. This deficient practice placed Resident 58 at a higher risk of acquiring and transmitting pneumonia to other residents in the facility. Findings: During a review of Resident 58's admission Record, the admission Record indicated the facility originally admitted the resident on 2/11/2019 and re-admitted the resident on 12/3/2025 with diagnoses including acute respiratory failure with hypoxia (a condition where your lungs suddenly cannot get enough oxygen into your blood), sepsis (a life-threatening condition that arises when the body's response to an infection causes injury to its own tissues and organs) and diabetes mellitus (DM- a chronic condition that affects the way the body processes blood sugar [glucose]). During review of Resident 58's Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2025, the MDS indicated Resident 58 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and was dependent from staff for activities of daily living (ADLs- bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a concurrent interview and record review on 12/3/2025 at 10:04 a.m., with the Infection Preventionist Nurse (IPN), reviewed Resident 58's immunization record and immunization consent forms. Resident 58's immunization record indicated Resident 58's last PNA vaccine (PNA23- type of PNA vaccine) dose was administered on 12/20/2023. Resident 58's immunization consent forms indicated a missing PNA vaccine consent. The IPN stated Resident 58's PNA vaccine consent form was missing and stated that she (IPN) was not sure why the PNA vaccine was not offered to Resident 58. The IPN also stated since Resident 58 received the first dose of PNA23, the second dose of PNA23 dose is needed and should have been offered to Resident 58. During an interview on 12/4/2025 at 8:28 a.m., with the Director of Nursing (DON), the DON verified by stating that Resident 58 was due for a PNA vaccine. The DON also stated that the facility was supposed to check and verify all residents' PNA vaccines and offer it as needed due to the risk of possible PNA infection if not given a vaccine. The DON also stated that Resident 58 was at high risk for PNA infection. During a review of the facility's policy and procedure (P&amp;P) titled, PNA Vaccine for Residents, reviewed on 5/14/2025, the P&amp;P indicated, Facility to offer residents PNA vaccine in accordance with the latest United States Department of Health and Human Services, and Centers for Disease Control and Prevention (CDC) recommendations. The P&amp;P also indicated, On admission, all residents will be evaluated for PNA vaccination status. each resident will be offered a PNA immunization, unless the immunization is medical contraindicated, or the resident has already been immunized.</p>		

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  12/04/2025
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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on interview and record review, the facility failed to ensure a Coronavirus Disease (COVID-19, a severe respiratory illness caused by virus and transmitted from person to person) vaccination was administered after a resident's representative gave consent (agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) to be vaccinated for one of seven sampled residents (Resident 14). This deficient practice placed Resident 14 at a higher risk of acquiring (to get) and transmitting (pass on) the COVID-19 virus to other residents in the facility. Findings: During a review of Resident 14's admission Record, the admission Record indicated the facility admitted the resident on 6/25/2025 with diagnoses including hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body), and cerebral infarction (lack of blood flow resulting in severe damage to some of the brain tissue). During review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 10/1/2025, the MDS indicated Resident 14 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and was dependent from staff for activities of daily living (ADLs- bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS also indicated that Resident 14 was not up to date with COVID-19 vaccination. During a concurrent interview and record review on 12/3/2025 at 10:04 a.m., with the Infection Preventionist Nurse (IPN), reviewed Resident 14's immunization record, immunization consent form dated 11/14/2025, and physician order summary were reviewed. Resident 14's immunization record indicated Resident 14's last COVID-19 dose was on 11/16/2021. Resident 14's immunization consent form indicated Resident 14's representative verbally consented for Resident 14 to have a COVID-19 booster vaccine on 11/14/2025. Resident 14's physician order summary indicated no COVID-19 vaccine was ordered and/or administered for Resident 14. The IPN verified all documents and stated she (IPN) has not provided a COVID-19 booster vaccine to Resident 14. The IPN stated they are supposed to provide a COVID-19 vaccine to residents once consented by the resident and/or resident's representative. The IPN also stated that it is important to offer a COVID-19 vaccine to the residents due to possible risk of COVID-19 infection. During an interview on 12/4/2025 at 8:28 a.m., with the Director of Nursing (DON), the DON verified by stating that Resident 14's immunization consent form was consented by Resident 14's representative on 11/14/2025 for a COVID-19 booster vaccine. The DON also stated that it was important for the facility to administer a COVID-19 vaccine to residents if the resident and/or residents' representative gave consent, to lessen the risk of contracting COVID-19 infection. During a review of the facility's policy and procedure (P&amp;P) titled, COVID-19 Vaccine, reviewed on 5/14/2025, the P&amp;P indicated, COVID-19 vaccinations will be offered to all staff and residents per CDC (Centers for Disease Control and Prevention) and/or FDA (Food and Drug Administration) guidelines unless immunization is medically contraindicated, the individual has already been immunized during the time period or the individual refuses to receive the vaccine.</p>		