

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/28/2024
NAME OF PROVIDER OR SUPPLIER The Pavilion at Sunny Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2222 N. Harbor Blvd. Fullerton, CA 92835	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47746</p> <p>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of four sampled residents (Resident 4).</p> <p>* The licensed nurse failed to prime Resident 4's Tresiba (insulin pen injection) prior to administering the insulin medication as per the manufacturer's instructions for the use of insulin pen medication. This failure posed the risk for complications related to the resident not receiving the correct amount of the prescribed medication.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Insulin Administration effective 2/2024 showed the nursing staff will have access to specific manufacturer's instructions on all forms of insulin delivery system prior to their use. Under the section for Insulin Delivery, the forms of insulin delivery include the pens containing insulin cartridges to deliver insulin subcutaneously through a needle.</p> <p>Review of the Manufacturer's Instruction for Use for Tresiba (insulin degludec) injection revised 7/2022 showed the following steps for priming the Tresiba insulin pen injection:</p> <ul style="list-style-type: none"> - Step 7: Turn the dose selector to select two units. - Step 8: Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. - Step 9: Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0 (zero). A drop of insulin should be seen at the needle tip, if you do not see a drop of insulin, repeat step 7 to 9, no more than six times. - Step 10: Selecting your dose: Turn the dose selector to select the number of units you need to inject. <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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/23/24 at 0831 hours, a medication administration observation was conducted with LVN 1. LVN 1 was observed preparing Resident 4's medications, including the Tresiba insulin pen injection. LVN 1 was observed cleaning the tip of the Tresiba insulin pen, twisted the needle onto the pen, and then immediately turned the dose selector to the number of units to be administered to Resident 4. LVN 1 was observed entering Resident 4's room and administered the prepared medications, including the Tresiba insulin injection. However, LVN 1 did not prime the insulin pen injection as per the manufacturer's instructions for use.</p> <p>An interview was conducted with LVN 1 following the medication administration observation. LVN 1 was asked how he prepared the Tresiba insulin pen injection for Resident 4. LVN 1 stated he sanitized the top of the pen, attached the needle, and then selected the number of units to be administered based on the physician's orders.</p> <p>Medical record review for Resident 4 was initiated on 5/23/24. Resident 4 was admitted to the facility on [DATE], with diagnoses including DM Type 2.</p> <p>Review of Resident 4's Order Summary Report showed a physician's order dated 5/13/24, to administer Tresiba FlexTouch subcutaneous solution pen-injector 200 units/ml (insulin degludec), inject 12 units subcutaneously one time a day for DM Type 2.</p> <p>Review of Resident 4's MAR for May 2024 showed LVN 1 administered the Tresiba insulin medications to Resident 4 on 5/13, 5/14, 5/15, 5/16, 5/17, 5/20, 5/21, 5/22, 5/23, and 5/24/24.</p> <p>On 5/23/24 at 1315 hours, a follow-up interview was conducted with LVN 1. LVN 1 explained the steps to prepare the insulin pen injections. However, LVN 1 acknowledged he was not aware the insulin pen should be primed prior to selecting the dose for injection.</p> <p>On 5/23/24 at 1317 hours, an interview was conducted with RN 1. RN 1 explained the steps to prepare the insulin pen injections. However, RN 1 acknowledged she was not aware the insulin pen should be primed prior to selecting the dose for injection.</p> <p>On 5/23/24 at 1524 hours, an interview was conducted with the ADON. The ADON was informed and acknowledged the above findings. The ADON verified the insulin pen should be primed prior to selecting the numbers of the unit dose for injection.</p>		