STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555733	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Sunny Hills	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of three sampled residents (Resident 1). * The facility failed to follow up with the hospice for the latanoprost eye drop (to treat glaucoma) order for Resident 1. This failure had the potential to negatively impact the resident's well-being. Findings: Review of the facility's P&P titled Hospice Services revised March 2023 showed the nursing home staff may obtain the orders for care from the designated hospice physicians and communicate the necessary changes initiated by the hospice provider to the resident's attending physician/practitioner in a timely manner. The nursing home shall communicate changes in orders provided by the resident's attending physician/practitioner in the facility if he/she is not the resident's designated physician on the hospice team. Review of the facility's Hospice and Nursing Facility Services Agreement signed 4/4/24, showed when the facility personnel are directed by the hospice to administer the prescribed therapies to the residents who are under hospice's care, including those therapies determined appropriate by the hospice and delineated in the plan of care, the facility personnel shall administer the therapies in accordance with applicable law and thefacility policies and procedures. Review of Resident 1's medical record was initiated on 7/30/24. Resident 1was admitted to the facility on [DATE]. Review of Resident 1's physician's order for July 2024 showed an order dated 6/3/24, to admit the resident for hospice care. Review of Resident 1's MDS Change of Condition assessment dated [DATE], showed Resident 1 was able to make self-understood and understand others. Review of Resident 1's plan of care showed a care plan problem for actual impaired vision related to diabetes mellitus was initiated on 6/22/24, with the interventions to administer the medications as ordered and monitor for side effects and effectiveness. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's hospice physician's order dated 6/29/24, showed an order for latanoprost solution (used for glaucoma) 0.005 % one drop to both eyes at bedtime. Review of Resident 1's hospice pharmacy delivery receipt showed the eye drop latanoprost solution 0.005 % was received by LVN 2 on 6/30/24. Review of Resident 1's SNF physician's orders and MAR from 6/29/24 to 7/8/24, failed to show an order for latanoprost solution (used for glaucoma) 0.005 % one drop to both eyes at bedtime. Review of Resident 1's progress notes from 6/29/24 to 7/8/24, failed to show documentation regarding the new order for the resident's eye drop. Further review of Resident 1's Order Summary Report for July 2024 showed an order dated 7/9/24, to administer latanoprost solution 0.005 % one drop in both eyes at bedtime. On 7/30/24 at 1215 hours, an interview with Resident 1 was conducted. Resident 1 stated he received his eye drops at night. Resident 1 further stated he had eye discomfort, and it was bothersome for weeks before he received his eye drops. On 7/30/24 at 1435 hours, an interview and concurrent medical record review with the MDS nurse was conducted. The MDS nurse verified the resident had a care plan initiated on 6/22/24, for impaired vision. The MDS nurse verified the order for latanoprost was received on 7/9/24. On 7/30/24 at 1523 hours, a telephone interview was conducted with the hospice Case Manager. The hospice Case Manager verified the order for the latanoprost solution 0.005 % was sent to the facility through facsimile. The Case Manager stated the eye drop medication latanoprost solution was received by the facility nurse signed on 6/30/24. On 7/30/24 at 1633 hours, an interview and concurrent medicalrecord review with the DON was conducted. The DON stated the hospice agency usually wrote the order or would facsimile the order to the facility and would call the facility nurse for a new order. The DON stated the nurse who received the medication delivered by the hospice pharmacy should havefollowed up with the order for the new medication for the resident. The DON verified the order for latanoprost solution 0.005% was started on 7/9/24, instead of 6/30/24, when the staff received the order from the hospice agency and the eye drop from the pharmacy. On 7/31/24 at 1329 hours, a telephone interview was conducted with LVN 2. LVN 2 verified she received the eye drop latanoprost solution for Resident 1 on 6/30/24,and stated it slipped through her mind and was not able to verify and carry out the order for the latanoprost solution 0.005% eye drop.