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	03/18/2025

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** 49348 Based on interview, medical record review, and the facility P&P review, the facility failed to provide the necessary care and services to maintain the highest practicable well -being for one of two sampled residents (Resident 2). * The facility failed to ensure Resident 2 had a physician's order for suctioning as per the discharge order from the acute care hospital. * The facility failed to weigh daily and provide the Lasix medication to Resident 2 as per the physician's instructions. * The facility failed to notify the physician and responsible party of Resident 2's continued refusals of the medications and supplements. * The facility failed to provide Resident 2's indwelling urinary foley catheter care, and wound care treatments as ordered by the physician. These failures had the potential to negatively affect the resident's well-being as the necessary care and services were not provided. Findings: Closed medical record review for Resident 2 was initiated on 3/5/25. Resident 2 was admitted to the facility on [DATE] and transferred to the acute care facility on 1/30/25. Resident 2's diagnoses included COPD, heart failure, Stage 3 CKD, and hydronephrosis. 1. Review of the facility's P&P titled Admission Orders for Immediate Care revised 1/2025 showed the facility obtains a physician's orders for the immediate care of the resident at the time of admission. Review of the facility's P&P titled Physicians Orders revised 5/2019 showed whenever possible the licensed nurse receiving the order will be responsible for documenting and implementing the order. Review of Resident 2's Post Acute Care Facility Physician Admission Orders dated 12/9/24, the section for Respiratory Therapy/Care showed to suction per facility protocol unless otherwise specified. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Order Summary Report for December 2024 and January 2025, did not show the respiratory therapy/care suctioning orders. Review of Resident 2's Care Plan Report dated 12/20/24, showed a care plan problem to address Resident 2's altered respiratory status, risk for respiratory distress, difficulty breathing/SOB r/t diagnosis of asthma/COPD overlap syndrome, emphysema, and CHF. The interventions includedto maintain a clear airway by encouraging to clear own secretions with effective coughing, and if the secretions cannot be cleared, suction as ordered/required to clear secretions. Review of Resident 2's Progress Notes showed the following: - dated 1/28/25 at 2311 hours, showed the resident during AM was using the suctionmachine on his own, and put it all the way back to his throat causing the resident to vomit, no episode noted during the shift and the resident was educated on proper way to use the suction device, and - dated 1/29/25 at 0722 hours, showed progress note for 1/28/25 . The note further showed the CNA came up to the nurse to let her know the patient was using the suctioning machine on his own and the Yankauer to the back of his throat and made himself throw up. On 3/5/25 at 1526 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 stated the suctioning required a physician's order, and notification of the resident's family member. LVN 2 verified Resident 2's admission orders from the acute care hospital included suctioning, and the plan of care showed to suction as ordered. LVN 2 verified Resident 2 did not have a physician's orders for suctioning the resident upon admission to the facility. LVN 2 stated the nurse who received the physician's orders should have entered the suction orders. 2. Review of Resident 2's After Visit Summary dated 1/10/25, a physician's instructions showed to continue to monitor your weight every day. If your weight goes up by 3-5 pounds in one day, or you notice extra swelling, OK to take one extra Lasix (medication used for hypertension) pill a day for 1-3 days. Review of Resident 2's Order Summary Report for January 2025 did not show a physician's order to monitor Resident 2's weights daily. Review of Resident 2's Weights and MAR for January 2025 did not show Resident 2's weights were monitored from 1/10 to 1/30/25. On 3/7/25 at 1710 hours, a follow up interview and concurrent closed medical record review was conducted with LVN 2 and the ADON. LVN 2 and the ADON verified Resident 2 did not have a physician's order for daily weight monitoring, and stated there should have been a weight monitoring. 3. Review of the facility's P&P titled Notification of Changes revised 1/2025 showed the facility notifies the physician and resident representative of a need to alter treatment significantly, (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment. Review of the facility's P&P titled Develop-Implement Comprehensive Care Plans revised 1/2025 showed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A resident may choose to refuse services or treatments that staff believe may be indicated to assist the resident in reaching his or her highest practicable level of well-being or to keep the resident safe. 2. When a resident's choice to decline care or treatment poses a risk to the resident's health or safety, the comprehensive care plan must: a. identify the care or service being declined; b. the risk for declination poses to the resident; c. efforts by the interdisciplinary team to educate the resident and the representative as appropriate; and d. attempts to find alternative means to address the identified risk. Review of Resident 2's Order Summary Report showed the following orders: - dated 12/9/24,for Breyna Inhalation Aerosol (breathing treatment) 160-4.5 mcg/act, two puffs inhale orally two times a day, and Spiriva Respimat Inhalation Aerosol Solution (breathing treatment) 2.5 mcg/act, two inhalations inhale orally one time a day, and - dated 12/17/24, for Suplena 1.8/CarbSteady Oral Liquid (nutritional supplement), give one can by mouth one time a day. Review of Resident 2's MAR for January 2024, showed a documentation of 2. (indicating Resident 2 refused) for the following medications, dates and times: - Breyna Inhalation Aerosol on 1/1, 1/3, 1/6, 1/9, 1/11, 1/12, 1/15-1/18, 1/21-1/24, and 1/27/25 at 0900 hours, and at 1700 hours: 1/3, and 1/6/25 at 1700 hours; - Spiriva Respimat Inhalation Aerosol Solution on 1/1, 1/3, 1/4, 1/6, 1/9, 1/15-1/18, 1/22-1/25, and 1/27/25 at 0900 hours; and - Suplenaon 1/1-1/4, 1/6-1/9, and 1/11-1/30/25 at 0900 hours. On 3/18/25 at 1647 hours, an interview and concurrent closed medical record review for Resident 2 was conducted with the ADON. When asked what the 2 indicated in Resident 2's MAR, the ADON stated drug refused. When asked what the expectation was when there weremultiple consecutive refusals of the medications or supplements, the ADON stated to notify the physician. When asked if the physician had been notified, the ADON stated, they should have been notified, and when there are three consecutive refusals, a COC/SBAR is advised . When asked if there was a COC/SBAR for refusals, the ADON stated, nothing . When asked what is included in a COC/SBAR the ADON stated to notify the MD and responsible party, obtain vital signs, do an assessment of the resident, and the resident would be monitored for 72 hours after a COC. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Review of the facility's P&P titled Medication and Treatment Orders revised 2/2023 showed the Care plans must be person-centered and reflect the resident's goals for admission and desires outcomes, interventions that reflect the resident's cultural preferences, values, and practices. The interdisciplinary team develops the care plan with the corresponding interventions for care that is in accordance with the professional standards of practice and accounting for residents' experiences and preferences to climate or mitigate triggers that may cause re-traumatization of the resident. Review of Resident 2's Care Plan Report showed the following care plan problems to address the following: - Resident 2 was admitted in the facility with an indwelling urinary catheter initiated on 12/20/24. The interventions included for indwelling urinary catheter care daily and PRN, and - thehigher risk/potential for pressure ulcer development, skin breakdown, secondary to decreased mobility. Resident 2 was admitted with left and right gluteal and sacrococcyx Stage 1 pressure ulcer initiated on 12/10/24. The interventions included to administer treatments as ordered and monitor for effectiveness. Review of Resident 2's Order Summary Report showed the following physician's orders: - dated 12/10/24, for the indwelling urinary catheter, monitor everyshift for change in urine character, and indwelling urinary catheter care daily and PRN as needed. Review of Resident 2's TAR for January 2025, showed blank entries on the following dates and treatment orders: - on 1/4, 1/5, 1/11, 1/12, 1/18, 1/25, 1/26, and 1/31/25, for the indwelling urinary catheter care daily and PRN; - on 1/4 and1/5/25, for the indwelling urinary catheter monitoring every shift for change in urine character; -on 1/18/25, for the right gluteal pressure injury Stage 2, to cleanse with NS, pat dry, apply foam dressing; and - on 1/4 and 1/5/25 on the day shift, and 1/6/25 on the evening shift, for the left gluteal pressure injury Stage 1, to cleanse with NS, pat dry, apply zinc oxide every day and evening shift for 14 days, left groin erythema (redness) to cleans with NS, pat dry, apply zinc oxide every day and evening shift for 14 days, right gluteal pressure injury Stage 1, to cleanse with NS, pat dry, apply zinc oxide every day and evening shift for 14 days, and right groin erythema to cleanse with NS, pat dry, apply zinc oxide, every day for 14 days. On 3/18/25 at 1647 hours, an interview and concurrent closed medical record review was conducted with the ADON. When asked what the blank entries were in Resident 2's TAR indicated, the ADON stated if blank, it was never done. On 3/19/25 at 1347 hours, the Administrator and DON was made aware and acknowledged the above findings.

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 49348 Based on observation, interview, and the facility P&P review the facility failed to comply with the State laws as evidenced by LVN 3 and CNA 2 not wearing their name badges. This failure had the potential to negatively affect the resident's emotional well-being as they are not able to identify the person providing their care. Findings: Review of the facility's P&P titled Name Badges revised 3/2024 showed the name badges are a required part of the employee dress standards. On 3/6/25 at 1239 hours, a concurrent observation and interview was conducted with CNA 2. CNA 2 was observednot wearing her name badge. When asked, CNA 2 stated, it fell off, I'm going to put it on now. On 3/6/25 at 1251 hours, a concurrent observation and interview was conducted with LVN 3. LVN 3 was observed not wearing her name badge. LVN 3 stated the purpose of the name badges was for the residents and family could see their names if they had questions and know they were the employees ofthe facility. When asked if name badges are to be worn at all times, LVN 3 stated yes. When asked where her name badge was, LVN 3 stated on the cart. On 3/18/25 at 1455 hours, an interview was conducted with the ADON. When asked what the expectations of the staff wearing their name badges were, the ADON stated they should be worn at all times, as it is a part of their uniform.