

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 07/10/2025
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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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: 555733	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2025
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to report an allegation of abuse to the Administrator of the facility, CDPH L&C Program, Long-Term Care Ombudsman, and local law enforcement in a timely manner for one of four sampled residents (Resident 10) reviewed for abuse allegations. * The facility's staff reported allegations of abuse to the administrator of the facility, CDPH L&C Program, Long-Term Care Ombudsman, and local law enforcement, around eight hours after the staff from the Acute Care Hospital had voiced concerns about Resident 10's allegation of abuse and mistreatment in the facility. This failure had the potential to delay the investigation of the alleged abuse and for the staff not to take prompt and appropriate corrective actions to prevent the alleged abuse. Findings: Review of the facility's P&P titled Abuse Prohibition and Prevention Program revised April 2024 showed the facility shall ensure that all alleged violation involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with state law through established procedures. Medical record review for Resident 10 was initiated on 7/9/25. Resident 10 was admitted to the facility on [DATE], and discharged on 7/8/25. Review of Resident 10's H&P examination dated 7/5/25, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's Progress Notes showed the following: - On 7/8/25 at 0054 hours, the staff in the facility called the Acute Care Hospital via telephone on 7/8/25 at 0050 hours, and spoke to the RN of the Acute Care Hospital who informed the staff upon discharge that Resident 10 told the RN of the Acute Care Hospital she did not want to go back to the facility because as per Resident 10, she was abused and mistreated at the facility. - On 7/8/25 at 0944 hours, the investigation for an alleged mistreatment and SOC 341 was submitted. On 7/9/25 at 1516 hours, a telephone interview was conducted with LVN 6. LVN 6 stated on 7/7/25, Resident 10 was transferred to the acute care hospital. LVN 6 stated on 7/8/25 around midnight, she spoke to the RN of the acute care hospital who informed her that Resident 10 verbalized she did not want to go back to the facility because she was abused and mistreated at the facility. LVN 6 stated the Administrator was the abuse coordinator of the facility. LVN 6 stated she reported the incident to the RN supervisor in the facility on duty; however, she did not report the allegation made by Resident 10 to the Administrator of the facility, nor did she report the incident to CDPH L&C Program, Long-Term Care Ombudsman, and local law enforcement. LVN 6 stated she should have reported the allegation made by Resident 10 to the Administrator right away. On 7/9/25 at 1607 hours, an interview was conducted with the Administrator. The Administrator stated he was the Abuse Coordinator in the facility. The Administrator stated the facility staff should report to him right away any allegation of abuse and mistreatment made by the resident, and he would then report the allegation to CDPH L&C Program, Long-Term Care Ombudsman, and local law enforcement not later than two hours after the allegation was made. The Administrator stated he was notified about the above allegation made by Resident 10 on 7/8/25 at around 0800 hours, (approximately 8 hours after the allegation was made) then he reported the incident to CDPH L&C Program, Long-Term Care Ombudsman, and local law enforcement. The Administrator further stated the staff should have reported the allegation made by Resident 10 right away. On 7/10/25 at 1417 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>		