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	12/08/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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
	555733	A. Building B. Wing	12/08/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 2) was free from unnecessary restraints. * The facility failed to ensure there was a physician's order and informed consent for the use of a lap buddy and pressure pad alarm for Resident 2's wheelchair. Additionally, there was no care plan developed for the use of the lap buddy and pad alarm. These failures posed the risk of compromising the resident's independence and psychosocial well-being.Findings: Review of the facility's P&P titled Respect and Dignity - Physical Restraints revised 3/2023 showed the following:- Physical Restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body (e.g. leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, and lap trays the resident cannot remove easily);- The following practices shall be considered a physical restraint including, but not limited to using devices in conjunction with a chair, such as trays, tables, cushions, bars, or belts, that theresident cannot remove and prevents the resident from rising, using a position change alarm to monitor resident movement, and the resident is afraid to moveto avoid setting off the alarm;- Physical restraints may increase the risk of one or more of the following: decline in physical functioning including an increased dependence in activities of daily living (e.g., ability to walk), impaired muscle strength and balance, decline in range of motion, and risk for development of contractures;- Psychosocial impact related to the use of physical restraints may include one or more of thefollowing:a. Agitation, aggression, anxiety, or development of delirium.b. Social withdrawal, depression, or reduced social contact due to the loss of autonomy.c. Feelings of shame.d. Loss of dignity, self respect, and identity.e. Dehumanization; Panic, feeling threatened or fearful; andf. Feelings of imprisonment or restriction of freedom of movement;- The licensed nurse shall obtain a physician's order for the use and specific type of restraint;- The interdisciplinary team shall complete a physical restraint assessment to identify potential risks associated with the restraint use, specific to the resident;- The interdisciplinary team will complete a resident centered care plan, based on the restraintassessment with individualized interventions for care;- The interdisciplinary team will provide on-going documentation for the use of the physical restraint and use the restraint for the least amount of time possible, with ongoing re-evaluation;- Residents, or the resident representatives, may refuse the use of a restraint, even when medically warranted to treat a medical symptom; and- The failure to immediately obtain an order is viewed as the application of restraint without an order and supporting documentation. Review of the facility's P&P titled Informed Consent revised 2/2024 showed the following:- Informed consent is the voluntary agreement of a patient or a representative of an incapacitated patient to accept a treatment or procedure after receiving information from a licensed healthcare provider to determine material information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure;- Each resident has the right to participate in their healthcare planning and decision making including the request, refusal, and/or discontinue treatment, and the right to receive written disclosure in a language they understand;- A copy of the signed, written consent must be given to the resident or their representative.;- It is the responsibility of the prescribing physician, or approved licensed healthcare provider, to personally examine and obtain written informed consent, whereby applicable and indicated by state & federal regulations, from a resident or their representative for the use of:a. Physical restraints.b. Psychotherapeutic medications, and/orc. The prolonged use of a device that may lead to the inability to regain use of a normal bodily function; and- The licensed nurse receiving an order for a restraint or psychotherapeutic medication will not apply the restraint or administer the medication until verification of a written informed consent signed by the prescribing physician is documented in the resident's medical record. Medical record review for Resident 2 was initiated on 12/4/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 6/3/25, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2's BIMS score was 00, indicating severe cognitive impairment. On 12/4/25 at 1100 hours, an observation and concurrent interview was conducted with the Activity Assistant. The Activity Assistant verified Resident 2 had a lap buddy and pad alarm on the wheelchair. The Activity Assistant stated Resident 2 had episodes of leaning forward, and the pad alarm and lap buddy would alert staff if the resident got up by himself or needed

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	12/08/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	12/08/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 two of five sampled residents (Resident 2 and 3). * The facility failed to ensure Resident 2's abnormal Neurological Assessment findings were reported to the physician. * The facility failed to ensure Resident 3 was monitored post fall on 12/2/25, for the morning and night shifts. These failures posed the risk of the residents not receiving appropriate care and the potential for a delay in providing care to the residents.Findings: Review of the facility's P&P titled Neurological Exam revised 3/2023 showed the following:- A neurological exam, also called a neuro exam, is an evaluation of a person's nervous system that can be completed in the healthcare setting;- The licensed nurse completes the neurological assessment flow record in accordance with documented time intervals;- Results will be documented in the residents' medical record;- Noted changes in the resident's neurological assessment from their usual baseline will be reported to the physician; and- The major areas of the exam, covering the most testable components of the neurological system, include:a. Level of Consciousnessb. Pupil Responsec. Hand Grasps d. Extremitiese. Pain Response f. Vital Signsg. Observation. Review of the facility's P&P titled Documentation revised 3/2023 showed the following:- 72-hour charting shall be initiated at the following times - this list is not all inclusive and nursing may use their judgment based on clinical condition.a. Significant change in physical, mental, or psychosocial status of the resident (progression, regression, new problems); andb. An extraordinary event occurs (e.g. fall or injury). Review of the facility's P&P titled Fall Management Program revised 3/2023 showed the following:- After a fall or other similar accident, the resident shall have a physical assessment documented in the nursing notes in accordance with the general facility policy on documenting by exception. The attending physician and resident representative or interested family member shall be notified of the incident; and- The facility shall begin charting for a minimum of 72 hours after the fall or related accident and continue to assess for latent injuries or changes in condition. 1. Medical record review for Resident 2 was initiated on 12/4/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 6/3/25, showed Resident 2 had no capacity to understand and make decisions. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2's BIMS score was 00, indicating severe cognitive impairment. Review of Resident 2's Progress Note dated 11/26/25, showed at around 0430 hours, the resident was found laying on his right side facing away from the bed. The resident had an open laceration on his forehead on the right side above his right eye.PERRLA 4 mm.resident was at baseline neuro. Neuro check was initiated for 72 hours. Received orders to transfer the resident to the emergency room, resident left at 0530 hours to go to the acute care hospital. Review of Resident 2's Progress Note dated 11/26/25, showed at around 1700 hours, the resident returned to the facility from the acute care hospital. Review of Resident 2's 72 Hour Neurological assessment dated [DATE], showed to inform the attending physician if there was a deviation from the resident's normal status. Further review of the document showed the key legend for pupil reaction was coded 1 for brisk, 2 for sluggish, and 3 for fixed. The document showed Resident 2 had the following abnormal findings for the right and left pupil reaction when the resident returned to the facility from the acute care hospital:- dated 11/26/25 at 2015 hours, '3' for fixed right and left pupil reaction; and- dated 11/27/25 at 0815, 1215, 1615, and 2015 hours, '3' for fixed right and left pupil reaction. Review of Resident 2's medical record failed to show documented evidence the resident's physician was notified of the abnormal neurological findings when the resident was readmitted to the facility on [DATE] at 1700 hours. On 12/8/25 at 1522 hours, an interview and concurrent medical record review for Resident 2 was conducted with the ADON. The ADON verified Resident 2's fixed pupil reaction were abnormal findings and should have been reported to the physician. The ADON stated the physician should have been notified and the notification should have been documented. 2. Medical record review for Resident 3 was initiated on 12/4/25. Resident 3 was admitted on [DATE], and readmitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 11/28/25, showed Resident 3 had fluctuating capacity to understand and make decisions. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3's BIMS score was 15, indicating intact cognition. Review of Resident 3's SBAR dated 12/2/25, showed the resident experienced an unwitnessed fall on 12/2/25, at around 0410 hours. Review of Resident 3's medical record failed to show documented evidence the resident was monitored post fall on 12/2/25, for the morning (0700-1500 hours) and night shift (2300-0700 hours). On