

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  01/30/2026
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, medical record and facility document review, the facility failed to provide respiratory care services for two of six sampled residents (Residents 2 and 3). * The facility failed to ensure Resident 2's nebulizer mask and tubing was bagged and labeled with the resident's name and date. In addition, the facility failed to ensure the oxygen in use signage was placed on the outside of Resident 2's door. * The facility failed to ensure Resident 3's oxygen tubing was properly stored when not in use. In addition, the facility failed to ensure oxygen in use signage was placed on the outside of Resident 3's door. These failures had the potential for the residents to not receive the appropriate respiratory care, increase the risks of infection and negatively affect the residents' well-being. Findings: 1. Review of the facility's P&amp;P titled Nebulizer (Aerosol) Therapy dated January 2026 showed after the completion of the nebulization therapy under infection control consideration:- to take care not to contaminate mask, mouthpiece, and/or internal tubes;- to store in a plastic bag, marked with date and resident's name, between uses; and- discard the administration set- up every seven days. Review of the facility's P&amp;P titled Oxygen Therapy dated March 2023 showed Oxygen in Use signs shall be placed outside in the room entrance door on oxygen. Medical record review for Resident 2 was initiated on 1/30/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed a physician's order date 1/8/26, to administer albuterol- ipratropium (bronchodilator) inhalation solutions 2.5 -0.5 mg per 3 ml inhale orally every six hours via nebulizer. Review of Resident 2's H&amp;P examination dated 1/12/26, showed Resident 2 did not have the capacity to understand and make decisions. Review of Resident 2's MAR for January 2026 showed the albuterol- ipratropium medication was last administered on 1/30/26 at 0600 hours. On 1/30/26 at 0920 hours, an observation was conducted in Resident 2's room. A nebulizer mask was observed face down and the nebulizer tubing connected to the nebulizer machine on top of Resident 2's nightstand were not dated and not stored in a bag. In addition, Resident 2's room was observed with an oxygen concentrator being used by Resident 2 at bedside and two portable small oxygen tanks. However, there was no oxygen in use signage outside of Resident 2's room. On 1/30/26 at 0935 hours, during an interview with the OT, the OT verified the nebulizer mask and nebulizer tubing connected to the nebulizer machine was on top of Resident 2's nightstand. The OT verified the mask and tubing was not dated and not stored in a bag. The OT stated, I saw that. On 1/30/26 at 0943 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified the nebulizer mask was observed face down and the nebulizer tubing connected to the nebulizer machine was on top of Resident 2's nightstand. LVN 4 verified the mask and the tubing was not dated and not stored in a bag. LVN 4 further stated the mask and the tubing should have been bagged and dated. LVN 4 further verified there was no oxygen in use signage by the entrance of Resident 2's room. 2. Review of the facility's P&amp;P titled Oxygen Therapy showed, all oxygen tubing, humidifiers, masks and cannulas used to deliver oxygen are for single resident use only, will be changed weekly</p> <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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>and when visibly soiled, and will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. Medical record review for Resident 3 was initiated on 1/30/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 2's care plan for asthma dated 1/20/26, showed give oxygen therapy as ordered by the physician. Review of Resident 3's MDS assessment dated [DATE], showed a BIMS score of 12 (moderately impaired cognition). Review of Resident 3's Order Summary Report dated 1/30/26, showed may use oxygen via nasal cannula at one to five LPM as needed to maintain oxygen of more than 92%. On 1/30/26 at 0945 hours, an observation was conducted in Resident 3's room. The oxygen tubing curled around the portable oxygen tank was not bagged and labeled. The portable oxygen tank was inside an oxygen holder at the back of Resident 3's wheelchair. In addition, Resident 3 was on oxygen therapy using an oxygen concentrator via nasal canula. However, there was no oxygen in use signage outside of Resident 3's room. On 1/30/26 at 0949 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified Resident 3's oxygen tubing curled around the oxygen tank at the back of Resident 3's wheelchair was not bagged and labeled. CNA 3 also verified Resident 3's entrance door did not have an oxygen in use sign. On 1/30/26 at 0952 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 3's oxygen tubing curled around the oxygen tank at the back of Resident 3's wheelchair was not bagged and labeled. LVN 5 stated it should have been bagged and labeled. LVN 5 also verified there was no oxygen in use signage in Resident 3's room entrance door. On 1/30/26 at 1100 hours, an interview was conducted with the IP. The IP was informed and acknowledged the above findings. The IP stated the oxygen and nebulizer tubing should be changed, bagged and dated by the night shift once a week and as needed. The IP stated there should be an oxygen in use signage for all rooms with residents using oxygen. The IP further stated the oxygen and nebulizer tubing should have been bagged and dated when not in use.</p>		