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	03/26/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care were revised to reflect the specific care needs for one of seven sampled residents (Resident 1). * The facility failed to revise Resident 1's care plan problem for a heart monitoring device. * The facility failed to revise Resident 1's care plan problem for urinary retention. * The facility failed to revise Resident 1's care plan problem for rectal bleeding. These failures placed the resident at risk to not receive the necessary care to safely maintain the resident's physical well-being.Findings: Review of the facility's P&P titled Comprehensive Care Plans-Timing revised 1/2025 showed each resident has a person-centered, comprehensive care plan, developed, reviewed, and revised by the facility interdisciplinary team including the resident and resident representative, if applicable. Intent: To ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed, and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. Closed medical record review for Resident 1 was initiated on 3/17/26. Resident 1 was admitted to the facility on [DATE], and discharged on 2/25/26. Review of Resident 1's Plan of Care for January 2026 did not show a care plan problem addressing the Zio patch (a wearable, adhesive, single-use electrocardiogram monitor that continuously records heart rhythms for seven to 14 days to diagnose arrhythmias like atrial fibrillation). 1.a. Review of Resident 1's Discharge to SNF Summary and Transfer Order dated 1/14/26, showed the following:- other findings requiring follow up or further workup as outpatient, cardiac monitor- reasons for hospitalization: atrial fibrillation Review of Resident 1's Wound Weekly Monitoring Assessment-Non-Pressure v1 dated 1/15/16, showed the Zio patch was present upon admission. b. Review of Resident 1's Plan of Care for January 2026 did not show a care plan problem addressing the resident's urinary retention. Review of Resident 1's Discharge to SNF Summary and Transfer Order dated 1/14/26, showed the reason for the acute care hospitalization was urinary retention. Review of Resident 1's Order Summary Report dated 1/15/26, showed a physician's order to check PVR (Post Void Residual) Q six hours x (times) three days. I/O (In and out catheter if PVR greater than 250 cc. Notify MD if two or more consecutive catheterizations, every six hours for three days. c. Review of Resident 1's Plan of Care for January 2026 did not show a care plan problem addressing the resident's rectal bleeding. Review of Resident 1's Order Summary Report dated 1/17/26, showed a physician's order to monitor the signs and symptoms of the rectal bleeding. On 3/25/26 at 0900 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with RN 1. RN 1 verified Resident 1 was identified with a Zio patch upon admission. When asked if it should be care planned, RN 1 stated, I believe it should. RN 1 verified there was no care plan problem initiated for the Zio patch. On 3/26/26 at 0915 hours, an interview and concurrent closed medical review for Resident 1 was conducted with the ADON. The ADON verified there were no care plans for the urinary retention and rectal bleeding, and verified a care plan should have been revised to reflect the care plan problems. On 3/26/26 at (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1325 hours, the Administrator, Administrator Assistant, ADON, and the DON were informed and acknowledged the above findings.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to provide the necessary care and services for one of seven sampled residents (Resident 1). * The facility failed to follow the physician's order to perform I/O (in and out), for PVR (post volume residual) greater than 250 cc for Resident 1; * The facility failed to notify the physician about Resident 1 was still retaining urine on 1/18/26, and the procedure to perform I/O for a residual of 337 cc was not performed; and * The facility failed to monitor Resident 1 after the resident was identified to have retained urine on 1/18/26. These failures had the potential to negatively impact the resident's well-being.Findings: Review of the facility's P&P titled Physician Orders revised 5/2019 showed whenever possible, the licensed nurse receiving the order will be responsible for documenting and implementing the order. Review of the facility's P&P titled Bowel and Bladder Retraining dated 2/2023 showed the interdisciplinary team provide appropriate and sufficient services and assistance to:a. maintain bladder continence and/or bowel function in continent residents;b. restore bladder continents and/or bowel function as possible based on a comprehensive assessment and clinical condition;c. prevent urinary tractions to the extent possible;d. ensure that a resident is not catheterized unless required by his/her clinical condition; ande. ensure that a urinary catheter is removed as soon as possible unless the catheter is necessary because of the residence clinical condition. 1. Each resident's continence status is assessed at admission and as needed such as when there is a change in urinary tract function. 2. The continence assessment may include but is not limited to:a. prior history of bladder functioning and previous treatment and/or management, including the response to interventions and the occurrence of persistent or recurrent UTI (urinary tract infection);b. voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and for those already experiencing urinary incontinence, voiding patterns over several days. Closed medical record review for Resident 1 was initiated on 3/17/26. Resident 1 was admitted to the facility on [DATE], and discharged on 2/25/26. Review of Resident 1's Plan of Care for January 2026 did not show a care plan problem for urinary retention. Review of Resident 1's Order Summary Report dated 1/15/26, showed a physician's order to check PVR Q six hours x (times) three days. I/O (catheter if PVR greater than 250 cc. Notify MD if two or more consecutive catheterizations, every six hours for three days. Review of Resident 1's Medication Administration Record dated 1/18/26 at 1200 hours, showed the PVR was 337 cc. Further review of the Medication Administration Record showed this was the last documented PVR sequence. Review of Resident 1's Progress Note dated 1/18/26, showed no documentation an I/O catheterization was performed, as ordered by the physician, for a PVR of 337 cc. Review of Resident 1's closed medical record for 1/18/26 at 1200 hours, did not show Resident 1 was reassessed after retaining 337 cc of urine. Further review of the record did not show an I/O catheterization was performed per physician's order, the physician was not notified of the retention, and no further monitoring was conducted. On 3/25/26 at 0900 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with RN 1. RN 1 stated if the resident was still retaining urine after three days, the physician should be notified, there should be reassessment, monitoring, and a care plan problem should be created. RN 1 stated the monitoring would include an assessment for the abdomen tenderness, the amount or urine the resident was voiding, and if briefs were saturated or scant. RN 1 verified the above findings. On 3/26/26 at 1325 hours, the Administrator, Administrator Assistant, ADON, and DON were notified and acknowledged the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the timely intervention for one of seven sampled residents (Resident 1) identified with weight loss. * The facility facility failed to address Resident 1's significant weight loss of seven lbs. in nine days, then five lbs. weight loss eight days after, totaling 12 lbs. weight loss in less than a month. This failure had the potential to result in continued nutritional decline and negative outcomes.Findings: Review of the facility's P&P titled Weight Management revised 12/2024 showed the following:- residents who have a sudden change in nutritional intake and are at risk for significant weight loss or exhibited gradual weight loss/gain;- residents who have lost or gained 5 lbs. since the last recorded weight;- residents who have lost or gained greater than 5% of their body weight in the last month;- residents who have lost or gained greater than 7.5% of their body weight in the last three months;- residents who have lost or gained greater than 10% of their body weight in the last six months- residents who are currently receiving aggressive interventions for weight and or nutritional management that were reviewed the week prior;- residents with aggressive weight loss requiring close observation;- residents monitored during the weekly weight management meeting may be weighed weekly until his or her condition stabilizes or as determined by the IDT evaluation of resident needs. Closed medical record review for Resident 1 was initiated on 3/17/26. Resident 1 was admitted to the facility on [DATE], and discharged on 2/25/26. Review of Resident 1's Weight and Vitals Summary showed the following weights:- dated, 1/15/26, a weight of 187 lbs.;- dated 1/24/26, a weight of 180 lbs.;- dated 2/1/26, a weight of 175 lbs ; (-5% change, comparison weight 1/15/26, 187 lbs., -6.4%, -12 lbs.)- dated 2/8/26, a weight of 175 lbs. Review of Resident 1's Nutritional Assessment/Evaluation dated 1/21/26, showed the resident's goal weight was 185-190 lbs. Further review showed the rate of unplanned weight gain/loss showed no weight change was checked off. Review of Resident 1's IDT Progress Note for Weight Variance and Nutritional Condition dated 2/9/26, showed the resident's Wt.175 lbs. (2/8/26), no change x 1 week, -5# x 2 weeks, -12# 6% x 3 weeks since admission. On 3/25/26 at 1407 hours, an interview and concurrent closed medical record review for Resident 1 was conducted with the RD. The RD stated she received copies of the weekly weights. When asked if a seven pound weight loss in nine days would be concerning and require a follow-up, the RD stated, Yes. When asked when she followed up on Resident 1, RD stated on 2/9/26. RD further stated ideally she should have followed up Resident 1. When asked if Resident 1 had significant weight loss, RD stated Yes, it was six percent from admission. On 3/26/26 at 1325 hours, the Administrator, Administrator Assistant, ADON, and DON were informed and acknowledged the above findings.