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	05/26/2026

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 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** Based on interview, closed medical record review, and facility P&P review, the facility failed to ensure the quality care and services were provided for one of eight sampled residents (Resident 5) reviewed for accidents. * The facility failed to ensure two staff performed Resident 5's transfer to her bed while using a mechanical lift. * The facility failed to notify Resident 5's physician when the resident reported hitting her neck and/or head during a mechanical lift transfer experiencing pain. In addition, the facility failed to document and monitor the resident for potential injury. These failures had the potential for Resident 5 not to receive the necessary care and services to maintain the highest physical well-being.Findings: Review of the facility's SOC 341 dated 5/11/26, showed during a post-discharge telephone call with Resident 5, the resident alleged she felt mistreated while at the facility and referenced an incident during a mechanical lift transfer. The facility reported that the incident had been previously investigated and determined a CNA had transferred the resident by herself using a mechanical lift without using a second staff member to assist, and the resident had bumped her head on the headboard. Closed medical record review for Resident 5 was initiated on 5/26/26. Resident 5 was admitted to the facility on [DATE], and transferred to the acute care hospital on 5/7/26. Review of Resident 5's H&P examination dated 5/11/26, showed the resident had the capacity to understand and make decisions. The H&P also showed the resident had a fractured tibia and fibula with a long-leg immobilizer. a. Review of CNA 5's Invacare Mechanical Lift Competency dated 9/27/23, showed to use an assistant for all lifting preparation, transferring from, and transferring to procedures. One will maneuver the machine, and one to assist, safeguard the pt to avoid injury. b. Review of Resident 5's closed medical record failed to show documentation the resident reported hitting her neck or head during a mechanical lift transfer, and/or complained of any pain or discomfort to her neck or head. Afterward. In addition, the medical record failed to show the physician was notified of the incident and failed to show continued monitoring for potential injury and pain of the resident's neck or head. Review of Resident 5's Skin Monitoring: Comprehensive CNA Shower review dated 5/4/26, signed by LVN 2 showed no new skin impairment or redness. On 5/26/26 at 1134 hours, a telephone interview was conducted with Resident 5. Resident 5 stated while at the facility, CNA 5 transferred her from her wheelchair to her bed using a mechanical lift without a second CNA assisting her, as required. The resident stated CNA 5 raised her too high in the lift, and her fractured leg in the immobilizer was not properly supported, resulting in pain. Resident 5 stated when the CNA lowered the lift, she hit her neck on the headboard, causing additional pain. Resident 5 stated she did not report it at the time because the CNA appeared to be in a bad mood. The next morning, she was still in pain and informed CNA 1 what had happened. The CNA returned with the licensed nurse and the resident informed both staff members about her neck pain, but no follow-up action was taken. Resident 5 stated one staff member usually maneuvered the lift, and the other staff supported her leg. On 5/26/26 at 1205 hours, a telephone interview was conducted with CNA 5. CNA 5 stated she did transfer Resident 5 using a mechanical lift by herself and acknowledged she should have had a second staff member assist her. CNA 5 stated the resident did not hit her head on the headboard, but the resident had told her the lift was positioned too high. On 5/26/26 at 1343 hours, an (continued on next page)

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	interview was conducted with CNA 1. CNA 1 stated when she entered Resident 5's room in the morning, the resident appeared upset and reported her head hurt because CNA 5 had transferred her alone using the mechanical lift, raised her too high, and caused her to hit her head on the headboard. CNA 1 stated she notified LVN 2. CNA 1 verified two staff members were required for mechanical lift transfers. On 5/26/26 at 1348 hours, an interview and concurrent closed medical record review was conducted with LVN 2. LVN 2 stated on 5/4/26, she was notified of Resident 5's incident. However, after reviewing Resident 5's MAR for May 2026, LVN 2 acknowledged the notification occurred on 5/5/26. LVN 2 stated the SSD came to her before CNA 1 and informed her Resident 5 reported an incident and stated she had hit her head on the headboard. LVN2 stated she assessed the resident and found no injury. When asked about documentation and notification, LVN 2 stated she completed a paper body check but did not document elsewhere because there was no injury, and did not need to notify the resident's physician. On 5/26/26 at 1354 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON stated if a resident reported hitting their head on the headboard during a transfer and continued to experience pain the next day, the licensed nurse should notify the physician and perform neurological checks. The DON initially stated this did not apply because the resident was discharged when the facility became aware of the incident. However, upon being informed the resident reported the incident on 5/5/26, while still in the facility, the DON stated that the nurse should have notified the physician and monitored the resident for possible injury. The DON verified Resident 5's medical record failed to show documentation of the resident reporting the incident, physician notification or , continued monitoring. On 5/26/26 at 1400 hours, an interview was conducted with the SSD. The SSD stated on 5/5/26, after Resident 5's care conference, the resident asked if he could stay behind, and reported CNA 5 transferred her without assistance and that she almost hit her head on the headboard.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to follow infection control standards for one of eight sampled residents (Resident 7). * The facility failed to ensure Resident 7's floor mat was stored properly. The floor mat was temporarily propped up against the side of the resident's bed, with the surface of the mat touching the bed linen. This failure placed the risk for contamination of Resident 7's bedding and the potential spread of microorganisms, increasing the risk of infection.Findings: Medical record review for Resident 7 was initiated on 5/26/27. Resident 7 was admitted to the facility on [DATE]. On 5/26/26 at 1030 hours, an observation and concurrent interview was conducted with CNAs 2 and 3. CNAs 2 and 3 were observed using a mechanical lift to transfer Resident 7 from his bed to a wheelchair. Resident 7 was observed lying in his bed. A floormat was observed propped up lengthwise against the left side of Resident 7's bed and the upper grab bar, with the upper portion of the floormat touching the resident's bedding. A photograph was taken documenting the floormat's placement. CNA 2 stated he had moved Resident 7's the floormat off the floor and leaned it against the resident's bed to make while performing the mechanical lift to transfer Resident 7. CNA 2 verified the floor and items placed on the floor are considered contaminated and acknowledged he should have placed the floormat against the wall instead of the resident's bed. On 5/26/26 at 1333 hours, an interview was conducted with the DON. The DON stated any items on the floor were considered dirty. The DON stated the floormat should not have been leaned along Resident 7's bed and acknowledged the issue as an infection control concern.