STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555045	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Healthcare Center	10158 Sunland Blvd Sunland, CA 91040

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 39550 Based on interview and record review, the facility failed to develop a comprehensive person-centered care plan (a plan for an individual's specific health needs and desired health outcomes) to address a diagnosis of heart failure (a condition in which the heart doesn't pump blood as well as it should) for one of three sampled residents (Resident 1). This deficient practice had the potential to negatively affect the delivery of care and services to Resident 1 due to the absence of the comprehensive care plan. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 10/19/2023 and readmitted Resident 1 on 10/28/2023. Resident 1's last re-admission was on 12/20/2023 with diagnoses that included Non-ST-Elevation Myocardial Infarction (NSTEMI- a type of heart attack that usually happens when your heart's need for oxygen can't be met), heart failure, and unstable angina (chest discomfort or pain caused by insufficient blood and oxygen flow to the heart). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 11/4/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 required maximum assistance from staff with oral hygiene and personal hygiene and was dependent on staff with toileting hygiene, showering and dressing. The MDS also indicated an active diagnosis of heart failure. During an interview and concurrent record review with MDS Nurse (MDSN) on 5/21/2024 at 11:59 a.m., the MDSN reviewed Resident 1's care plans from 10/28/2023 to 1/5/2024. The MDSN stated that there was no documented evidence a comprehensive person-centered care plan was developed to address Resident 1's diagnosis of heart failure. The MDSN stated that Resident 1 should have had a care plan developed specific to heat failure within 14 days of admission. The MDSN stated that a care plan specific to heart failure is important because a care plan will guide staff what specific interventions to provide to Resident 1 when necessary. (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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered, last revised 10/11/2023, indicated a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (admission, annual or significant change in status), and no more than 21 days after admission.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review the facility failed to provide the necessary care and services in accordance with its policy and procedure for one of three sample residents (Resident 1), as evidenced by: 1. Failing to schedule an appointment for follow up care with cardiology (branch of medicine that specializes in diagnosing and treating diseases of the heart and blood vessels) within two weeks (per instructions from the General Acute Care Hospital [GACH]) after being readmitted to the facility on [DATE] and within one week (per instructions from the GACH) after being readmitted to the facility on [DATE]. 2. Failing to schedule an appointment for follow up care with pulmonology (branch of medicine dealing with diseases involving the respiratory tract [the organs that are involved in breathing]) within one week (per instructions from the GACH) after being readmitted to the facility on [DATE]. 3. Failing to ensure monitoring was provided to Resident 1 after a change in condition (COC- when there is a sudden change in a resident's health) on 10/31/2023. These deficient practices have a potential to cause a negative outcome to Resident 1's physical health and well-being. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 10/19/2023 and readmitted Resident 1 on 10/28/2023. Resident 1's last re-admission was on 12/20/2023 with diagnoses that included Non-ST-Elevation Myocardial Infarction (NSTEMI- a type of heart attack that usually happens when your heart's need for oxygen can't be met), heart failure, and unstable angina (chest discomfort or pain caused by insufficient blood and oxygen flow to the heart). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 11/4/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 required maximum assistance from staff with oral hygiene and personal hygiene and was dependent on staff with toileting hygiene, showering and dressing. The MDS also indicated an active diagnosis of heart failure. A review of Resident 1's GACH discharge summary dated 10/28/2023 timed at 10:47 a.m., indicated to arrange for follow up care with cardiology within 2 weeks. A review of Resident 1's GACH discharge summary dated 12/20/2023 timed at 4:18 p.m., indicated to arrange for follow up care with pulmonology and cardiology within 1 week. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During an interview and concurrent record review with the MDS Nurse (MDSN) on 5/21/2024 at 11:41 a.m. , the MDSN reviewed Resident 1's GACH discharge summary records dated 10/28/2023. The MDSN stated Resident 1 had discharge instructions from the GACH to follow up with cardiology within 2 weeks. The MDSN continued to review Resident 1's nursing progress notes from 10/28/2023 to 12/12/2024. The MDS stated that she was unable to find documented evidence that a cardiology appointment was made for Resident 1. That MDSN further stated Resident 1's cardiology appointment should have been communicated with the Interdisciplinary Team (IDT - group of health care professionals who work together toward the goals of the resident) to ensure Resident 1's cardiology appointment was made. When asked who is responsible for arranging appointments for the resident, the MDSN stated the Social Services Director (SSD) is in charge of making residents' appointments. During an interview with the SSD, on 5/21/2024 at 12:30 p.m., the SSD stated that nursing department is responsible in making residents' appointment. During an interview and concurrent record review with Registered Nurse 2 (RN 2) on 5/21/2024 at 1:44 p.m., RN 2 reviewed the GACH discharge summary records dated 12/20/2023. RN 2 stated Resident 1 had discharge instructions from the GACH to follow up with cardiology within one week of discharge. RN 2 continued to review Resident 1's nursing progress notes from 12/20/2023 to 1/5/2024. RN 2 stated that RN 2 was unable to find documented evidence that a cardiology appointment was made for Resident 1. RN 2 stated that RN 2 was responsible for making all follow up appointments for the residents in the facility. RN 2 stated that she did not make Resident 1's cardiology appointment because she dropped the ball. When asked what should have been done, RN 2 stated that she should have made the cardiology appointments and double checked to make sure appointments were made timely. RN 2 further stated that she should have documented in the resident's clinical record if she made the appointments. 2. During an interview and concurrent record review with RN 2 on 5/21/2024 at 1:50 p.m., RN 2 reviewed the GACH discharge summary records dated 12/20/2023. RN 2 stated Resident 1 had discharge instructions from the GACH to follow up with pulmonology within one week of discharge. RN 2 continued to review Resident 1's nursing progress notes from 12/20/2023 to 1/5/2024. RN 2 stated that she was unable to find documented evidence that a pulmonology appointment was made for Resident 1 after being discharged from the GACH. RN 2 stated that it is important for Resident 1 to receive follow up care appointments and to follow discharge instructions from the GACH to ensure resident's needs are met and to maintain resident's health and safety while in the facility. A review of the facility's policy and procedure titled Admission Assessment and Follow Up: Role of the Nurse, last reviewed 10/11/2023, indicated the purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident. The policy further indicated to reconcile the discharge summary from the previous institution, according to established procedures. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an interview and concurrent record review with RN 2 on 5/21/2024 at 12:40 p.m., RN 2 stated that a change in a resident's condition is documented on a COC form. RN 2 further stated that after a change in a resident's condition is noted, the nursing staff must monitor the resident closely, every shift for 72 hours. RN 2 reviewed Resident 1's COC forms and stated that on 10/30/2023 at 6:00 p.m., Resident 1 was noted refusing medication and had delusional (false or unrealistic) beliefs. RN 2 continued to review Resident 1's nursing progress notes from 10/31/2023 to 11/3/2023. RN 2 stated that there was no documented evidence found that Resident 1 was monitored specifically to the change in condition noted on 10/30/2023. RN 2 stated that close monitoring after a change in condition is important so that licensed nurses will know if there is any worsening of symptoms. If there is any worsening of symptoms noted, licensed nurses can then notify the physician immediately and the proper intervention can be provided timely. A review of the facility's policy and procedure titled Change in a Resident's Condition or Status, last reviewed 10/11/2023, indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39550 Based on interview and record review, the facility failed to ensure the history and physical (H&P- is the starting point of the resident health concerns that explain why a resident sought medical attention or why a resident is now receiving medical attention) for one of three sampled residents (Resident 1) was completed by the attending physician upon Resident 1 ' s first admission to the facility on [DATE]. This deficient practice had the potential for inconsistent care coordination due to incomplete records. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 10/19/2023 and readmitted Resident 1 on 10/28/2023. Resident 1 ' s last re-admission was on 12/20/2023 with diagnoses that included Non-ST-Elevation Myocardial Infarction (NSTEMI- a type of heart attack that usually happens when your heart's need for oxygen can't be met), heart failure (a condition in which the heart doesn ' t pump blood as well as it should), and unstable angina (chest discomfort or pain caused by insufficient blood and oxygen flow to the heart). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 11/4/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 required maximum assistance from staff with oral hygiene and personal hygiene and was dependent on staff with toileting hygiene, showering and dressing. The MDS also indicated an active diagnosis of heart failure. During a concurrent interview and record review with Registered Nurse 2 (RN 2) on 5/21/2024 at 1:35 p.m., RN 2 reviewed Resident 1 ' s undated H&P document from the resident ' s admission on 10/19/2023 . RN 2 stated that Resident 1 ' s H&P undated) indicated that Resident 1 was admitted from home with no other medical information. RN 2 stated that the undated and incomplete H&P was signed by Resident 1 ' s attending physician with no date documented. RN 2 stated that Resident 1 ' s undated H&P did not have Resident 1 ' s pertinent medical information. RN 2 stated that it is import for all residents to have a completed and dated H&P to ensure that the resident ' s attending physician assessed the resident ' s condition on admission or readmission. A review of the facility ' s policy and procedure titled Physician Services, reviewed date 10/11/2023, indicated the medical care of each resident is supervised by a licensed physician. Supervising the medical care of resident ' s includes (but not limited to): a. participating in the resident ' s assessment and care planning; (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled Charting and Documentation last revised 7/2017 indicated that all services provided to the resident, progress towards the care plan goals, or any changes in the resident ' s medical, physical, functional, or psychosocial condition, shall be documented in the resident ' s medical record.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39550 Based on interview and record review, the facility failed to implement their facility ' s medication administration policy by failing to ensure Licensed Vocational Nurse 1 (LVN 1) signed and documented on the Medication Administration Record (MAR- a report detailing the medications administered to a resident by a healthcare professional) for one of three sampled residents (Resident 1) when LVN 1 did not administer Plavix (a medication used to prevent stroke and blood clots) on 12/21/2023. This deficient practice had the potential to result in medication errors and had the potential to result in confusion on the delivery of care and services. Findings: A review of Resident 1's Admission Record indicated the facility originally admitted Resident 1 on 10/19/2023 and readmitted Resident 1 on 10/28/2023. Resident 1 ' s last re-admission was on 12/20/2023 with diagnoses that included Non-ST-Elevation Myocardial Infarction (NSTEMI- a type of heart attack that usually happens when your heart's need for oxygen can't be met), heart failure (a condition in which the heart doesn ' t pump blood as well as it should), and unstable angina (chest discomfort or pain caused by insufficient blood and oxygen flow to the heart). A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and care screening tool) dated 11/4/2023, indicated Resident 1 was sometimes able to be understood by others and sometimes able to understand others. The MDS further indicated that Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making. The MDS indicated Resident 1 required maximum assistance from staff with oral hygiene and personal hygiene and was dependent on staff with toileting hygiene, showering and dressing. The MDS also indicated an active diagnosis of heart failure. A review of Resident 1 ' s order summary report indicated an order for Plavix oral tablet 75 milligrams (mg-unit of measurement) give one (1) tablet by mouth one time a day for Coronary Artery Disease (CAD-damage or disease in the heart ' s major blood vessels) with an order date of 12/20/2023. During an interview and concurrent record review with Registered Nurse 2 (RN 2) on 5/21/2024 at 2:20 p.m., reviewed Resident 1 ' s 12/2023 MAR. RN 2 further reviewed Resident 1 ' s MAR for December 2023 and stated that on 12/21/2023, LVN 1 was the assigned licensed nurse to administer Resident 1 ' s prescribed medication for the 7:00 a.m. to 3:330 p.m. shift. RN 2 stated that there was no documented evidence on Resident 1 ' s 12/2023 MAR that indicated Plavix was administered or refused by Resident 1 on 12/21/2023 at 9:00 a.m. RN 2 further stated that if the medication was administered to Resident 1, LVN 1 should have then documented LVN 1 ' s initial under the date and medication. A review of the facility ' s policy and procedure titled Administering Medications, reviewed date 10/11/2023, indicated medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescribers ' orders. The individual administering the medication initials the resident ' s MAR on the appropriate line after giving each medication.