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	12/18/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to: 1. Replace two (2) open used medication emergency kits ([eKIT] - storage container for emergency use medications) within 72 hours of opening the kit on 2/13/2025, and one (1) open used medication eKIT within 72 hours of opening the kit on 2/13/2025, in two (2) of two (2) inspected Medication Rooms (Medication Room Station 1 and Medication Room Station 2.)2. Reconcile (the process of comparing transactions and activity to supporting documentation) two (2) medication eKITs containing Controlled Drugs ([CD]-medications which have a potential for abuse and may also lead to physical or psychological dependence) for December 2025, in two (2) of two (2) inspected Medication Rooms (Medication Room Station 1 and Medication Room Station 2.)3. Reconcile three (3) medication eKITs containing CDs for December 2025, in one (1) of two (2) inspected Medication Carts (Medication Cart Station 2.)As a result, control and accountability of CDs and availability of medications did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CD diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and the risk that residents in the facility could have accidental exposure to harmful medications and delayed medication treatment during emergencies possibly leading to physical and psychosocial harm, and hospitalization.Findings: During an observation on 12/15/2025 at 11:10 a.m., with Registered Nurse (RN) 2, in Medication Room Station 1, there was: 1. One (1) open medication eKIT containing antibiotics (medications that are used to treat infections) with documents indicating the eKIT was opened on 12/10/2025, and again on 12/11/2025. The outside of the eKIT was labeled with a pink sticker stating, Need to Return within 72 hours of opening for compliance. 2. One (1) open medication eKIT containing intravenous (medications given through the vein) medications labeled IV180 with documents indicating the eKIT was opened on 12/11/2025. The outside of the eKIT was labeled with a pink sticker stating, Need to Return within 72 hours of opening for compliance. 3. One (1) medication eKIT containing CDs stored in the refrigerator and labeled AF133, without an accountability log for the reconciliation of CD inventory at every shift change for December 2025. During a concurrent interview, RN 2 acknowledged the antibiotic medication eKIT contained documents indicating the kit was opened on 12/10/2025 and again on 12/11/2025, used and awaiting replacement for a new one from pharmacy. RN 2 acknowledged the intravenous medication eKIT labeled IV180 contained documents indicating the kit was opened on 12/11/2025, used and awaiting replacement for a new one from pharmacy. RN 2 stated the medication eKITs should have been replaced with a new one from pharmacy within 72 hours of opening the kit. RN 2 stated according to the pink labels on the eKITs the facility was not compliant. RN 2 stated the facility failed to replace two (2) medication eKITs with a new one within 72 hours of opening the kits and this failure could increase the risk of not having emergency medications available for residents leading to negative consequence causing resident harm and potential hospitalization. During the same interview, RN 2 stated that all CDs, including medication eKITs containing CDs should be reconciled at every shift. RN 2 stated the eKIT labeled AF133 in the refrigerator containing CDs in Medication Room Station 1 was not reconciled at every shift in December 2025, and it was important to account for all (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
	555045	A. Building B. Wing	12/18/2025

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CDs to ensure accountability and prevent CD diversion. During an observation on 12/15/2025 at 11:55 a.m., with RN 1, in Medication Room Station 2, there was: 1. One (1) open medication eKIT containing antibiotics labeled A102 with documents indicating the eKIT was opened on 12/8/2025, and again on 12/9/2025. The outside of the eKIT was labeled with a pink sticker stating, Need to Return within 72 hours of opening for compliance. 2. One (1) medication eKIT containing CDs stored in the refrigerator and labeled AF172, without an accountability log for the reconciliation of CD inventory at every shift change for December 2025. During a concurrent interview, RN 1 acknowledged the antibiotic medication eKIT labeled A102 contained documents indicating the kit was opened on 12/8/2025 and again on 12/9/2025, used and awaiting replacement for a new one from pharmacy. RN 1 stated the medication eKIT should have been replaced with a new one from pharmacy within 72 hours of opening the kit. RN 1 stated according to the pink labels on the eKIT the facility was not compliant. RN 1 stated facility failed to replace one (1) medication eKIT with a new one within 72 hours of opening the kit and this failure could increase the risk of not having emergency medications available for residents leading to negative consequence causing resident harm and potential hospitalization. During the same interview, RN 1 stated that all CDs, including medication eKITs containing CDs, should be reconciled at every shift. RN 1 stated the eKIT labeled AF172 in the refrigerator containing CDs in Medication Room Station 2 was not reconciled at every shift in December 2025, and it was important to account for all CDs to ensure accountability and prevent CD diversion. During an observation on 12/15/2025 at 12:07 p.m., with RN 1, in Medication Cart Station 2, there was: 1. Three (3) medication eKITs containing CDs stored at room temperature and labeled NARC1 144, NARC2 131, and NARC2 093, without an accountability log for the reconciliation of CD inventory at every shift change for December 2025. During a concurrent interview, RN 1 stated that all CDs, including medication eKITs containing CDs should be reconciled at every shift. RN 1 stated the three (3) eKITs labeled NARC1 144, NARC2 131, and NARC2 093, containing CDs in Medication Cart Station 2 were not reconciled at every shift in December 2025, and it was important to account for all CDs to ensure accountability and prevent CD diversion. During an interview on 12/15/2025 at 2 p.m., with the Director of Nursing (DON,) the DON stated medication eKITs containing CDs needed to be counted and reconciled at every shift change to ensure accountability and prevent CD diversion. The DON stated eKITs labeled AF133 in refrigerator containing CDs in Medication Room station 1 and eKIT labeled AF172 in refrigerator in Medication Room Station 2, and three (3) eKITS labeled NARC1 144, NARC2 131, and NARC2 093, in Medication Cart Station 2 were not reconciled at every shift in December 2025. The DON stated that open eKITs needed to be replaced within 72 hours of opening to ensure emergency medications were available when needed for residents. The DON stated the facility was not in compliance by failing to replace the open antibiotic and intravenous eKITs in Medication Room Station 1 and antibiotic eKIT in Medication Room Station 2 within 72 hours of opening. The DON stated this failure can create potential harm for residents by not having critical medication readily available during emergency situations. During a review of facility's policy and procedures (P&P), titled Emergency Kit (e-kit) Use, last reviewed 10/8/2025, the P&P indicated: 6. The pharmacy is to be notified as soon as possible that the E-Kit has opened so that it can be replaced within 72 hours.10.and the controlled drugs (if any) will be counted each shift for accountability. During a review of facility's P&P, titled Controlled Drugs, last reviewed 10/8/2025, the P&P indicated: Drugs with high abuse potential will be subject to special handling, storage, disposal, and record keeping.KK. The DON is responsible for the accountability of these drugs.PP. These controlled drug records are physically counted at the change of each shift (on-coming nurse to count, off-going nurse to review the records for accuracy).

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	12/18/2025

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

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to ensure the safe and appropriate use of side rails (adjustable rigid plastic or metal bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) for two of three sampled residents (Residents 9 and 11) reviewed under restraints care area by failing to: 1. Ensure the facility conducted an accurate assessment of Resident 9's side rails and obtained an informed consent for the correct type of side rails, as the assessment and the informed consent did not reflect the type of side rails the resident was using. This failure had the potential to result in Resident 9 experiencing psychosocial harm and physical harm from entrapment (becoming caught between the rails and the mattress). 2. a. Ensure Resident 11's side rail assessments were completed for the correct length and number of side rails the resident was using. b. Ensure Resident 11's Side Rails Assessments form was not willfully falsified when it was altered to change the length and number of side rails the resident was using. c. Ensure an informed consent was obtained for the correct length and number of side rails Resident 11 was using. d. Ensure Resident 11's informed consent form was not willfully falsified when it was altered to change the length and number of side rails the resident was using. These failures resulted in the willful falsification of Resident 11's Side Rails Assessments form and informed consent for side rails and placed Resident 11 at an increased risk of adverse effects from side rails including, but not limited to, entrapment which could lead to death. Findings: 1. During a review of Resident 9's admission Record, the admission Record indicated the facility admitted the resident on 10/17/2025, with diagnoses that included muscle wasting and atrophy (shrinking muscle mass due to lack of use). During a review of Resident 9's Minimum Data Set (MDS – a resident assessment tool) dated 11/16/2025, the MDS indicated Resident 60 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 9 required maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left to right, sit-to-lying, lying to sitting on side of bed, and chair/bed-to-chair transfer. During a review of Resident 9's physician's orders, dated 12/15/2025, the physician's orders indicated an order for bilateral (on both sides) quarter (1/4) side rails up as enabler for turning and repositioning while patient on bed; responsible party consented and is aware of safety and entrapment risks. During a review of Resident 9's Side Rail Assessment, dated 12/15/2025, the assessment indicted Resident 9 was assessed for bilateral quarter side rails. During a review of Verification of Informed Consent for Chemical/Physical Restraints, dated 12/15/2025, the document indicated Resident 9's responsible party (RP 9) was notified by the resident's physician that Resident 9 would have bilateral quarter side rails. During a review of Resident 9's Care Plan (CP) for Quarter Side Rails, initiated 12/15/2025, the CP indicated a goal for minimizing risk for complication related to us of side rails daily for three months. The care plan indicated the following interventions:- Assess resident for the use side rails- Monitor (continued on next page)

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	12/18/2025

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

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's safety and risk for entrapment from side rails- Obtain informed consent During an observation and concurrent interview on 12/16/2025 at 11:45 a.m., with the Infection Preventionist (IP) observed Resident 9 was lying in his bed in his room. Observed middle side rails, that were longer than quarter side rails, on Resident 9's bed. During an interview and concurrent record review with the Infection Preventionist (IP) on 12/16/2025 at 11:45 a.m., Resident 9's care plans, informed consents and side rail assessments were reviewed. The IP stated Resident 9 had returned from a general acute care hospital (GACH, or simply hospital) on 12/15/2025. The IP confirmed that she had created the Care Plan for Quarter Side Rails, Verification of Informed Consent for Chemical/Physical Restraints, and the Side Rails Assessment. Went with the IP to Resident 9's room and confirmed that Resident 9's bed did not have quarter side rails but were larger than the quarter side rails and placed in the middle portion of the bed extending from resident's elbows to knees. The IP stated these were one-third (1/3) side rails and should not have been placed on Resident 9's bed. The IP stated the assessment, and informed consents should reflect what the type of bed rails the resident actually has on his bed. The IP stated this was important to ensure the resident was accessed correctly and could be at risk for entrapment with the one third side rails. The IP stated it is important to have the correct informed consent so that Resident 9's RP 9 is fully informed of the resident's condition. During an interview with the Director of Nurses (DON) on 12/17/2025 at 2:45 p.m. the DON stated Resident 9 should not have had the middle one-third side rails on his bed. The DON stated there should be one quarter side rails. The DON stated the assessment, and informed consent should reflect which side rails are actually in place. The DON stated Resident 9 could have been at risk for entrapment. The DON stated it is important to have the correct informed consent so that Resident 9's RP9 is fully informed of his condition. During a review of the policy and procedure titled, Bed Safety and Bed Rails, last reviewed 10/08/2025, indicated the following:- The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempt to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. - Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. 2. During a review of Resident 11's admission Record, the admission Record indicated the facility originally admitted Resident 11 to the facility on 5/30/2018 and readmitted the resident on 6/6/2025 with diagnoses including, but not limited to, muscle wasting and atrophy (the thinning, shrinkage, or decrease in size of a body part), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 11's History and Physical (H&P), dated 6/23/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS – a resident assessment tool), dated 10/23/2025, the MDS indicated Resident 11 had moderate cognitive impairment and required substantial assistance for most activities of daily living (ADLs- activities such as bathing, dressing (continued on next page)

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	12/18/2025

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

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and toileting a person performs daily). The MDS indicated Resident 11 required substantial assistance to roll left and right and was dependent on staff to move from lying to sitting on the side of the bed and transferring from the bed to a chair. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated the following order dated 6/6/2025: Bilateral side rails (1/2) x 4 up as enabler for turning and repositioning while patient on bed and feeling safe. Responsible party consented and aware of safety and entrapment risks. During a review of Resident 11's care plan (a document where you can summarize a person's health conditions, specific care needs, and current treatments), titled Resident Care Plan, dated 6/6/2025, the care plan indicated Resident requires to have 1/4 side-rails while in bed for repositioning & enabler. and to assess the resident for the use of side rails. During a review on 12/17/2025 of Resident 11's Verification of Informed Consent for Chemical/Physical Restraints, dated 6/6/2025, the Verification of Informed Consent for Chemical/Physical Restraints indicated informed consent was obtained from Resident 11's Responsible Party (RP 1), for Bilateral 1/4 siderails. During a concurrent observation, interview, and record review on 12/17/2025 at 1:40 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 11's Side Rails Assessments were reviewed. Observed Resident 11 in bed with four side rails up – two 1/3 length side rails on each side of the top half of the bed and two 1/4 length side rails on each side of the lower half of the bed. Resident 11's Side Rails Assessments form indicated assessments dated 6/6/2025, 7/26/2025, and 10/23/2025 were completed. The Side Rails Assessments form indicated Bilateral 1/4 Siderails in a section titled Approaches which indicated Siderails are indicated to enable positional changes and improve mobility in the bed. Not considered a restraint. LVN 2 stated the two siderails at the top of the bed were there to enable the resident to be able to turn and hold positions. LVN 2 stated the lower two 1/4 length siderails were removable and sometimes not there. LVN 2 stated he was not sure why the lower two 1/4 siderails were on the bed. LVN 2 stated the resident had a risk of entrapment because of the use of side rails. During a concurrent observation, interview, and record review on 12/18/2025 at 11:27 a.m. with the Minimum Data Set Coordinator (MDSC), reviewed Resident 11's Side Rails Assessments form which indicated bilateral 1/4 side rails were indicated to enable positional changes and improve bed mobility. The MDSC stated the resident has two not four siderails. Observed Resident 11 in bed with four side rails up – two 1/3 length side rails on each side of the top half of the bed and two 1/4 length side rails on each side of the lower half of the bed. The MDSC stated the Side Rails Assessments form was for two bilateral 1/4 side rails, not for four siderails. The MDSC stated there are risks from side rails such as bumping against the side rail. During a concurrent interview and record review on 12/18/2025 at 12:07 p.m. with the Director of Nursing (DON), Resident 11's Verification of Informed Consent for Chemical/Physical Restraints, dated 6/6/2025, and Side Rails Assessments form had both been altered with additional information with no indication of the date or author of the alteration. The Verification of Informed Consent for Chemical/Physical Restraints in the resident's chart now indicated consent was obtained for Bilateral 1/4 siderails & 1/3 siderails and still indicated the date of 6/6/2025. The DON reviewed a copy of the original, unaltered Verification of Informed Consent for Chemical/Physical Restraints and the one currently available in the chart. The DON stated the Verification of Informed Consent for (continued on next page)

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	12/18/2025

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

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Chemical/Physical Restraints was altered and she did not know why or who would have done that. The DON reviewed Resident 11's Side Rails Assessments form in the resident's chart which now indicated Bilateral 1/4 siderails & Bil 1/3 SR (bilateral 1/4 length and bilateral 1/3 length siderails) in the section titled Approaches. The Side Rails Assessments form still indicated assessments had been completed on 6/6/2025, 7/26/2025, and 10/23/2025. The DON stated she did not know why the Side Rails Assessments form was altered or who would have done that. The DON stated the original, non-altered Side Rails Assessments form indicated Bilateral 1/4 Siderails but the resident has used four side rails as the side rail order had indicated for years. The DON stated the original, non-altered Side Rails Assessments form does not reflect the side rails used by the resident and does not match the physician's order. The DON stated side rails have a possible risk of entrapment. During a concurrent interview and record review on 12/18/2025 at 12:32 p.m. with Registered Nurse (RN) 2, a copy of the original, non-altered Verification of Informed Consent for Chemical/Physical Restraints and the altered one currently available in the chart were reviewed. RN 2 stated she was the one that verified the informed consent. RN 2 stated she spoke to RP 1 about the informed consent for bilateral 1/4 side rails. RN 2 stated she does not know why the Verification of Informed Consent for Chemical/Physical Restraints was different now in the chart or why it has a different number and type of side rails. RN 2 stated she did not change the form or contact RP 1 again about any changes. RN 2 stated the Verification of Informed Consent for Chemical/Physical Restraints should be accurate so they know that RP 1 was correctly informed about the risks and benefits of the side rails. During a concurrent interview and record review on 12/18/2025 at 2:16 p.m. with the Medical Records Director (MRD), a copy of a photograph of the original, non-altered Side Rails Assessments form and the altered Side Rails Assessments form currently in the resident's chart were reviewed. The MRD stated the two forms were different. The MRD stated he did not know why they were different or who would have made the change. The MRD stated that any changes made by staff must be dated in order to clarify what the changes were and when the change was made. The MRD reviewed a copy of the original, non-altered Verification of Informed Consent for Chemical/Physical Restraints and the altered one currently available in the chart. The MRD stated he did not know why they were different or who would have made the change. The MRD stated that any changes made by staff must be dated in order to clarify what the changes were and when the change was made. During a concurrent interview and record review on 12/18/2025 at 2:32 p.m. with the MDSC, a copy of a photograph of the original, unaltered Side Rails Assessments form and the Side Rails Assessments form currently in the resident's chart were reviewed. The MDSC stated she had completed the assessments on 7/26/2025 and 10/23/2025. The MDSC stated the two forms were different and the new form now indicated bilateral 1/3 and bilateral 1/4 siderails. The MDSC stated she did not know why the two forms were different and that she did not change the forms. The MDSC stated that if there is change to be made to the forms, staff must draw a line through the old information, initial and date the change, and inform the supervisor. During a concurrent interview and record review on 12/18/2025 at 2:37 p.m. with the Administrator (ADM), a copy of a photograph of the original, non-altered Side Rails Assessments form and the altered Side Rails Assessments form currently in the resident's chart were reviewed. The ADM stated if changes need to be made to resident records, the staff has to do it correctly to make sure everyone is informed and the records reflect what actually happened. A copy of the original, non-altered Verification of Informed Consent for Chemical/Physical Restraints and the altered one currently available in the chart were reviewed by ADM. The ADM stated he was not aware either document had been altered and he needed to start an investigation to see why this was done. The ADM stated it (continued on next page)

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	12/18/2025

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

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was inappropriate to add information on an informed consent without doing it the correct way, which would be to contact the resident's responsible party with the correct information and fill out another form with the correct date and information. The ADM stated the resident's responsible party has to be properly informed of the risks and benefits and this should be shown in the documentation. During a telephone interview on 12/18/2025 at 3:01 p.m. with RP 1, RP 1 stated no one from the facility had contacted her this week regarding any changes to the documentation in Resident 11's records or any other matters related to the resident. During a review of the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, last revised on 10/8/2025, the P&P indicated the use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The P&P further indicated staff shall inform the resident or resident representative about the benefits and potential hazards associated with bed rails and obtained informed consent. During a review of the facility's policy and P&P titled, Charting and Documentation, last revised on 10/8/2025, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's P&P titled, Charting Errors and/or Omissions, last revised on 10/8/2025, the P&P indicated the following:1. Accurate medical records shall be maintained by this facility.2. If an error is made while recording the data in the medical record, line through the error with a single line and correct the error. 3. If it is necessary to change or add information in the resident's medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition.4. Late entries in the medical record shall be dated at the time and entry and noted as a 'late entry.'5. All corrections, changes, or addenda must be signed and dated by the person making such entries.

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	12/18/2025

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

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Four (4) medication errors out of 24 total opportunities contributed to an overall medication error rate of 14.28% affecting two (2) of four (4) residents observed for medication administration (Resident 6 and 43.) The medication errors were as follows: 1. Resident 6 received ferrous sulfate (a supplement used to treat iron deficiency [having low amounts of iron in the blood] and anemia [a condition with lower-than-normal number of red blood cells,]) at a different time than ordered by Resident 6's physician. 2. Resident 43 received metoprolol (a medication used to for hypertension [HTN - a condition in which the blood vessels have persistently raised pressure,]) ferrous sulfate and aspirin (a medication used for cerebrovascular accidents ([CVA] - an interruption in the flow of blood to cells in the brain] prophylaxis [PPX - prevention,]) at a different time than ordered by Resident 43's physician. These failures had the potential to result in Resident 6 and 43 receiving suboptimal (less than standard) care, experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and resulting in Residents 6 and 43's health and well-being negatively impacted. Findings: During an observation on 12/15/2025 at 8:55 a.m., in Medication Cart Station 1, Registered Nurse (RN) 3 was observed administering aspirin 81 milligram ([mg]-a unit of measure of mass) chewable tablet, metoprolol 25 mg tablet and ferrous sulfate 325 mg tablet orally to Resident 43. Resident 43 was observed swallowing the aspirin, metoprolol and ferrous sulfate tablets with a glass of water. During an observation on 12/15/2025 at 9:29 a.m., in Medication Cart Station 1, RN 3 was observed administering ferrous sulfate 7.5 milliliter ([ml]-a unit of measure of volume) liquid orally to Resident 6. Resident 6 was observed swallowing the ferrous sulfate liquid followed by a glass of water. During an interview on 12/15/2025 at 12:15 p.m., with RN 3, RN 3 stated RN 3 administered ferrous sulfate 325 mg tablet, metoprolol 25 mg tablet and aspirin 81 mg chewable tablet during the morning medication administration at 8:55 a.m. to Resident 43. RN 3 acknowledged the physician order for Resident 43 specified to administer ferrous sulfate 325 mg, metoprolol 25 mg and aspirin 81 mg at 7:30 a.m. with breakfast or food to prevent stomach discomfort. RN 3 stated Resident 43 had breakfast between 7:15 and 7:45 a.m. RN 3 stated per facility policy there was a 60-minute window for medication administration and RN 3 administered ferrous sulfate, metoprolol and aspirin later than that timeframe. RN 3 stated RN 3 failed to administer ferrous sulfate, metoprolol and aspirin as prescribed by Resident 43's physician placing Resident 43 at risk of experiencing stomach irritation. RN 3 stated these were considered medication errors. During the same interview, RN 3 stated that RN 3 administered ferrous sulfate 7.5 ml liquid during the morning medication administration at 9:29 a.m. to Resident 6. RN 3 acknowledged the physician's order to Resident 6 specified to administer ferrous sulfate at 7:30 a.m. with food to prevent stomach discomfort. RN 3 stated Resident 6 had breakfast between 7:15 and 7:45 a.m. RN 3 stated that RN 3 administered the ferrous sulfate later than the facility 60-minute window allowance. RN 3 stated this was also considered a medication error. During an interview 12/15/2025 at 2 p.m., with the Director of Nursing (DON), the DON stated RN 3 failed to administer ferrous sulfate, metoprolol and aspirin tablets to Resident 43 and ferrous sulfate to Resident 6, on 12/15/2025 according to their physician orders, at their scheduled time of 7:30 a.m. with breakfast or food. The DON stated Resident 6 and 43 may be at risk for developing stomach irritation from receiving the medications when given much later than their scheduled times. The DON stated these were considered medication errors. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and that medications are administered at the right time to residents. During a review of Resident 6's admission Record (a document containing demographic and diagnostic information,) dated 12/15/2025, the document indicated Resident 6 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including anemia. During a review of Resident (continued on next page)

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	12/18/2025

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

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6's Order Summary Report, dated 12/15/2025, indicated Resident 6 was prescribed:1. Ferrous sulfate 220 mg per 5 ml to give 7.5 ml by mouth once a day for anemia with food, starting 12/9/2025. During a review of Resident 6's Medication Administration Record ([MAR] - a record of mediations administered to residents), for December2025, the MAR indicated Resident 6 was prescribed:1. Ferrous sulfate 220 mg per 5 ml 7.5 ml by mouth once a day for anemia with food, to give at 7:30 a.m. During a review of Resident 43's admission Record dated 12/15/2025, the document indicated Resident 43 was originally admitted to the facility on [DATE] with a diagnosis including iron deficiency, hypertensive heart disease, atrial fibrillation (a condition with irregular, fast heart rate caused by poor blood flow that increases risk for CVA). During a review of Resident 43's Order Summary Report, dated 12/1/2025, the report indicated Resident 43 was prescribed:1. Aspirin chewable 81 mg to give one (1) tablet by mouth once a day for CVA prophylaxis with food, starting 8/18/2024.During a review of Resident 43's MAR for December 2025, the MAR indicated Resident 43 was prescribed:1. Aspirin chewable 81 mg one (1) tablet by mouth once a day for CVA prophylaxis with food, to give at 7:30 a.m.During a review of the facility's policy and procedures (P&P,) titled Administering Medications, last reviewed 10/8/2025, the P&P indicated: Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with the prescriber orders, including any required timeframe.7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (example, before and after meal order).10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. During a review of the facility's P&P, titled Adverse Consequences and Medication Errors, last reviewed 10/8/2025, the P&P indicated: 2. An ?adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include:b. Side effect;4. The staff and practitioner shall strive to minimize adverse consequences by:a. Following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication;5. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.6. Examples of medications errors include:g. Wrong time; h. Failure to follow manufacturer instructions and/or accepted professional standards. During a review of the facility's P&P, titled Frequency of Meals, last reviewed 10/8/2025, the P&P indicated:2. The following meal times have been established by out facility for residents: Breakfast 7:15 a.m.

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	12/18/2025

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to: 1. Monitor and record the medication room temperature on the temperature monitoring log for December 2025, for two (2) of two (2) inspected Medication Rooms (Medication Room Station 1 and Medication Room Station 2.) 2. Remove and discard from use two (2) expired Calcium with Vitamin D (medications used as supplements) medication bottles for facility use, in accordance with manufacturer's requirements and facility policy and procedures, in one (1) of two (2) inspected Medication Rooms (Medication Room Station 2.) These failures increased the potential for residents in the facility to receive medications that were ineffective or toxic due to the inadequate storage monitoring, and for residents to experience medication adverse consequences resulting in the negative impact to their health and well-being. Findings:During an observation and concurrent interview on 12/15/2025 at 11:10 a.m., with Registered Nurse (RN) 3, in Medication Room Station 1, the room temperature monitoring log for December 2025 was not available. RN 3 stated the room temperature log for Medication Room Station 1 for December 2025 was missing and as a result RN 3 did not monitor the room temperature that morning (12/15/2025). RN 3 stated without a log containing documentation for room temperatures, it was implied that the Medication Room Station 1 room temperatures were not monitored. RN 3 stated the room temperatures should be monitored and documented every day during all shifts to ensure medications are properly maintained at an acceptable temperature range, and their potency (the strength of medication required to produce an effect) not affected. RN 3 stated if the room temperature was not monitored it was unknown if the temperatures were maintained within the acceptable range and if the medications were affected negatively. RN 3 stated using improperly stored medications can harm the residents and not help in treating their condition. During an observation, on 12/15/24 at 11:55 a.m., with Registered Nurse (RN) 1, in Medication Room Station 2, the following was found:1. The room temperature monitoring log for December 2025 was not available.2. Two (2) bottles of Calcium with Vitamin D tablets for facility stock was found stored in Medication Room Station 2 and labeled with an expiration date of November 2025 by the manufacturer.According to the manufacturer labeled date, the Calcium with Vitamin D tablets bottle should be discarded and removed from use by 11/30/2025. During a concurrent interview, RN 1 stated the room temperature log for Medication Room Station 2 for December 2025 was missing and without a log it implies the room temperatures were not monitored. RN 1 stated the room temperature should be monitored and documented every day to ensure medications are properly maintained at an acceptable temperature range, and their potency not affected. RN 1 stated if the room temperature was not monitored it was unknown if the temperatures were maintained and if the medications were affected negatively. RN 1 stated using improperly stored medications can harm the residents and not help in treating their condition. During the same interview, RN 1 stated that the two (2) Calcium with Vitamin D tablet bottles stored in Medication Room Station 2 was for facility stock and to be used for any resident with an order for Calcium with Vitamin D tablets from that medication room. RN 1 stated the Calcium with Vitamin D tablet bottles were labeled with an expiration date of November 2025 and needed to be removed from Medication Room Station 2 and placed in the expired medication bin by 11/30/2025 to be disposed of and not accidentally used for residents. RN 1 stated expired medications have lost potency and will not be effective when used for residents in the facility. During an interview on 12/15/2025 at 2 p.m., with the Director of Nursing (DON), the DON stated that the temperature of medication rooms should be monitored and documented daily. The DON stated not knowing the temperature of the medication rooms from lack of monitoring, may result in medications being stored in unacceptable temperature ranges and lose efficacy, and when used they will not be effective in treating the residents' conditions. During the same interview, the DON stated that expired (continued on next page)

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	12/18/2025

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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications have lost their potency and will not be effective in treating resident's condition. The DON stated that several licensed nurses failed to remove two (2) expired Calcium with Vitamin D bottles from Medication Room Station 2 according to facility and manufacturer guidelines. The DON stated these failures could potentially lead to the administration of expired medication to residents. The DON stated administering expired Calcium with Vitamin D to residents will not treat their condition. During a review of facility's Policy and Procedures (P&P), titled Drug Storage and Labeling, last reviewed on 10/8/2025, the P&P indicated: Drugs and biologicals will be stored in a safe, secure and orderly fashion.8. Drugs that are stored at room temperature will be stored in an area no warmer than 86 degrees Fahrenheit. During a review of facility's P&P, titled Drug Disposition, last reviewed on 10/8/2025, the P&P indicated: Outdated drugs.are to be properly marked and disposed of in accordance with California's Medical Waste Management Act.2. Discontinued or outdated non-controlled drugs are to be stored in a secure area designated for that purpose until picked up by the pharmaceutical waste disposal service of the pharmacy personnel.

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	12/18/2025

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

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Infection Preventionist (IP) checked the contents of a meal tray against diet ticket (slip of paper that indicates the specific meal being served to a resident based on their dietary restriction and preference, is placed by the enclosed plate on a tray) and physician's orders during lunch on 12/15/2025 for five (2, 14, 34, 43 and 45) of 63 residents who received food in the facility. This deficient practice had the potential for residents to not receive the correct prescribed diet, which could lead to health complications such as aspiration (the inhalation of foreign material such as food into the airways/lungs) and anaphylactic shock (severe, life-threatening allergic reaction that occurs rapidly after exposure to an allergen [such as certain foods, medications, or insect stings]).Findings:a. During a review of Resident 2's admission Record, the admission Record indicated the facility admitted the resident on 10/25/2024, with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).During review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 2 was dependent (helper does all the effort) on staff with eating. The MDS indicated Resident 2 was on a therapeutic diet (a physician-ordered meal plan modified to treat a specific disease or condition).During a review of Resident 2's Physician's Orders, the orders indicated a no added salt diet, easy to chew texture (for people who need softer, tender everyday foods that are easy to break apart with a fork or spoon), thin consistency liquids (regular drinks that flow freely, like water), dated 9/22/2025. b. During a review of Resident 14's admission Record, the admission Record indicated the facility admitted the resident on 6/22/2024 and re-admitted on [DATE], with diagnoses that included diabetes mellitus.During review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 was moderately impaired in cognition with skills required for daily decision making. The MDS indicated Resident 14 required moderate (helper does less than half the effort) assistance with eating. The MDS indicated Resident 14 was on a therapeutic diet.During a review of Resident 14's Physician's Orders, the orders indicated a no added salt diet, regular texture (normal, everyday foods for residents with no chewing or swallowing problems), thin consistency liquids, dated 9/22/2025. c. During a review of Resident 34's admission Record, the admission Record indicated the facility admitted the resident on 3/19/2025, with diagnoses that included heart failure (a condition in which the heart does not pump blood effectively throughout the body).During review of Resident 34's MDS, dated [DATE], the MDS indicated Resident 34 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 34 required moderate assistance with eating. The MDS indicated Resident 34 was on a therapeutic diet.During a review of Resident 34's Physician's Orders, the orders indicated a no added salt diet, regular texture diet, thin consistency liquids, dated 9/22/2025. d. During a review of Resident 43's admission Record, the admission Record indicated the facility admitted the resident on 2/09/2022, with diagnoses that included iron deficiency anemia (a condition where the body does not have enough healthy red blood cells due to lack of iron [an essential mineral]).During review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 43 was independent with eating. The MDS indicated Resident 43 was on a therapeutic diet.During a review of Resident 43's Physician's Orders, the orders indicated a no added salt diet, regular texture, thin consistency, dated 9/22/2025. e. During a review of Resident 45's admission Record, the admission Record indicated the facility admitted the resident on 12/02/2021, with diagnoses that included anemia.During review of Resident 45's MDS, dated [DATE], the MDS indicated Resident 45 was severely impaired in cognition with skills required for daily decision (continued on next page)

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	12/18/2025

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

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	making. The MDS indicated Resident 45 required moderate assistance with eating. The MDS indicated Resident 45 was on a mechanically altered diet (diet requiring a change in texture of food), therapeutic diet.During a review of Resident 45's Physician's Orders, the orders indicated a regular diet, easy to chew texture, thin consistency liquids, dated 12/07/2025. During a concurrent observation and interview with the Infection Preventionist nurse (IP) on 12/15/2025 at 12:15 p.m., observed IP checking diet tickets against the residents' physician's orders. The IP did not lift the tray lid to see what type of food was inside the tray. Observed a certified nursing assistant (CNA) take a tray from the rolling tray cart that contained 10 resident trays. When asked why she did not lift the tray lids, the IP stated she should have lifted them. The IP checked the trays again, lifting the tray lids and checked them with the physician orders. During an interview with the IP on 12/15/2025 at 12:40 p.m., she stated she should have lifted the tray lids to ensure what diet on the physician's orders was what the resident was receiving. The IP stated this is important to ensure a resident does not receive the wrong tray and be at risk for aspiration.During a concurrent interview and record review with the Director of Nurses (DON) on 12/15/2025 at 4 p.m., the DON reviewed the facility's policy and procedure titled, Food and Nutrition Services, last reviewed 10/18/2025. The DON stated the food services staff check the food trays first to ensure that the correct meal is provided and then checked again by the licensed nurses after leaving the kitchen. The DON referred to the item: if an incorrect meal is provided to ta resident, nursing staff will report it to the food service manager so that a new food tray can be issued. The DON stated to do that, the tray lids must be lifted to compare the food on the plate with a resident's physician's orders. The DON stated she wants the licensed nurses to check the trays to catch any errors that nutrition staff made; it is a secondary check. The DON stated this is important to ensure a resident has a diet specific to their needs. The DON stated if the resident gets the wrong tray, they could be at risk for aspiration.During a review of the facility's policy and procedure titled, Food and Nutrition Services, last reviewed 10/18/2025, the policy indicated the following:- Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable (pleasant to taste) and attractive, and it is serviced at a safe and appetizing temperature.- If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the food service manager so that a new food tray can be issued.

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	12/18/2025

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

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to ensure accurate medical records were maintained for two of 18 sampled residents (Residents 11 and 13) when:1. Resident 11's Side Rail Assessments form was altered without any indication of the date, time, or author.This failure resulted in the willful falsification of documentation related to Resident 11's side rails (adjustable rigid plastic or metal bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides). 2. Resident 13's list of medical diagnoses was incomplete and did not reflect all current diagnoses. The failure resulted in not providing an accurate clinical overview of Resident 13's health status, which could have resulted in issues related to resident safety, quality of care and continuity of care. Findings: 1.During a review of Resident 11's admission Record, the admission Record indicated the facility originally admitted Resident 11 to the facility on 5/30/2018 and readmitted the resident on 6/6/2025 with diagnoses including, but not limited to, muscle wasting and atrophy (the thinning, shrinkage, or decrease in size of a body part), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 11's History and Physical (H&P), dated 6/23/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS – a resident assessment tool), dated 10/23/2025, the MDS indicated Resident 11 had moderate cognitive impairment and required substantial assistance for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 11 required substantial assistance to roll left and right and was dependent on staff to move from lying to sitting on the side of the bed and transferring from the bed to a chair. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated the following order dated 6/6/2025: Bilateral side rails (1/2) x 4 up as enabler for turning and repositioning while patient on bed and feeling safe. Responsible party consented and aware of safety and entrapment risks. During a concurrent observation, interview, and record review on 12/17/2025 at 1:40 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 11's Side Rails Assessments were reviewed. Observed Resident 11 in bed with four side rails up – two 1/3 length side rails on each side of the top half of the bed and two 1/4 length side rails on each side of the lower half of the bed. Resident 11's Side Rails Assessments form indicated assessments dated 6/6/2025, 7/26/2025, and 10/23/2025 were completed. The Side Rails Assessments form indicated Bilateral 1/4 Siderails in a section titled Approaches which indicated Siderails are indicated to enable positional changes and improve mobility in the bed. Not considered a restraint. LVN 2 stated the two siderails at the top of the bed were there to enable the resident to be able to turn and hold positions. LVN 2 stated the lower two 1/4 length siderails were removable and sometimes not there. During a concurrent interview and record review on 12/18/2025 at 12:07 p.m. with the Director of Nursing (DON), Resident 11's Side Rails Assessments form in the resident's chart now indicated (continued on next page)

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	12/18/2025

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

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Bilateral 1/4 siderails & Bil 1/3 SR (bilateral 1/4 length and bilateral 1/3 length siderails) in the section titled Approaches. The Side Rails Assessments form still indicated assessments had been completed on 6/6/2025, 7/26/2025, and 10/23/2025. The DON stated she did not know why the Side Rails Assessments form was altered or who would have made the changes. The DON stated the original, non-altered Side Rails Assessments form indicated Bilateral 1/4 Siderails but the resident has used four side rails as the side rail order had indicated for years. The DON stated the original, non-altered Side Rails Assessments form does not reflect the side rails used by the resident and does not match the physician's order. During a concurrent interview and record review on 12/18/2025 at 2:16 p.m. with the Medical Records Director (MRD), a copy of a photograph of the original, non-altered Side Rails Assessments form and the altered Side Rails Assessments form currently in the resident's chart were reviewed. The MRD stated the two forms were different. The MRD stated he did not know why they were different or who would have made the change. The MRD stated that any changes made by staff must be dated in order to clarify what the changes were and when the change was made. During a concurrent interview and record review on 12/18/2025 at 2:32 p.m. with the MDSC, a copy of a photograph of the original, unaltered Side Rails Assessments form and the Side Rails Assessments form currently in the resident's chart were reviewed. The MDSC stated she had completed the assessments on 7/26/2025 and 10/23/2025. The MDSC stated the two forms were different and the new form now indicated bilateral 1/3 and bilateral 1/4 siderails. The MDSC stated she did not know why the two forms were different and that she did not change the forms. The MDSC stated that if there is change to be made to the forms, staff must draw a line through the old information, initial and date the change, and inform the supervisor. During a concurrent interview and record review on 12/18/2025 at 2:37 p.m. with the Administrator (ADM), a copy of a photograph of the original, non-altered Side Rails Assessments form and the altered Side Rails Assessments form currently in the resident's chart were reviewed. The ADM stated if changes need to be made to resident records, the staff has to do it correctly to make sure everyone is informed and the records reflect what actually happened. During a telephone interview on 12/18/2025 at 3:01 p.m. with RP 1, RP 1 stated no one from the facility had contacted her this week regarding any changes to the documentation in Resident 11's records or any other matters related to the resident. During a review of the facility's policy and P&P titled, Charting and Documentation, last revised on 10/8/2025, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's P&P titled, Charting Errors and/or Omissions, last revised on 10/8/2025, the P&P indicated the following:1. Accurate medical records shall be maintained by this facility.2. If an error is made while recording the data in the medical record, line through the error with a single line and correct the error. 3. If it is necessary to change or add information in the resident's medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition.4. Late entries in the medical record shall be dated at the time and entry and noted as a 'late entry.'5. All corrections, changes, or addenda must be signed and dated by the person making such entries. 2. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 8/5/2023 with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), muscle wasting and atrophy (loss of muscle tissue, mass, and strength), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), dementia (a progressive state of decline in mental abilities), and depression (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities). (continued on next page)

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	12/18/2025

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

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 13's Minimum Data Set (MDS – a resident assessment tool), dated 11/12/2025 indicated Resident 13's cognition (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) was moderately impaired. During review of Resident 13's physician order dated 8/5/2023, the order indicated Resident 13 was ordered to have Prozac (medication given to treat depression) oral capsule 20 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), 1 capsule by mouth one time a day for depression manifested by verbalization of sadness. During review of Resident 13's physician order, dated 12/4/2024, the order indicated Resident 13 was ordered to have Zyprexa (medication given to treat schizophrenia) oral tablet 2.5 mg, 1 tablet by mouth at bedtime for schizoaffective disorder manifested by talking to himself. During a review of Resident 13's care plan (CP) titled, Antidepressant, dated 8/12/2025, the CP indicated the resident has episodes of depression manifested by verbalization of sadness and has an order for Prozac 20mg. During a review of Resident 13's CP titled, Antipsychotic, dated 8/12/2025, the CP indicated that the resident has episodes of schizoaffective disorder manifested by talking to himself and has an order for Zyprexa 2.5 mg. During a concurrent interview and record on 12/17/2025 at 4:55 PM with the Director of Nursing (DON), Resident 13's Diagnosis Report, dated 9/7/2023 was reviewed. The report did not indicate Resident 13's diagnoses of schizoaffective disorder and depression. The DON stated that both the diagnoses of depression and schizoaffective disorder should be listed on Resident 13's Diagnosis Report but were not. The DON stated the Diagnosis Report should indicate Resident 13's current diagnoses to ensure a complete and accurate overview of Resident 13's health status. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 10/8/2025, indicated, The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P also indicated, Documentation in the medical record will be objective . complete and accurate.

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	12/18/2025

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

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one out of three sampled residents (Residents 5) investigated during review of physical restraints care area by failing to obtain a physician's order and informed consent and develop and implement a care plan on the use of a gait belt fastened around Resident 5's waist and the wheelchair. These deficient practices had the potential to result in the restriction of Resident 5's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (sliding down and getting caught between the belt and the wheelchair).Findings: During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including, but not limited to, metabolic encephalopathy (the loss of brain function due to a chemical imbalance in the blood), schizophrenia (a mental illness that is characterized by disturbances in thought), and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 10/7/2025, the MDS indicated Resident 5 had severe cognitive impairment (trouble with thinking, learning, and remembering clearly) and was dependent on staff to complete most activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). During an observation on 12/15/2025 at 3:01 p.m. in the activity room, Resident 5 was seated in his wheelchair with a gait belt fastened around his waist and the chair. The clasp of the gait belt was fastened behind the back of the wheelchair. During a telephone interview on 12/15/2025 at 3:16 p.m. with Resident 5's responsible party (RP 2), RP 2 stated she did not remember anyone from the facility contacting her about the need to restrain Resident 5 and to her knowledge, the facility had never used restraints on the resident. During a concurrent observation and interview on 12/15/2025 at 3:24 p.m. with the Director of Nursing (DON) in the activity room, Resident 5 was seated in his wheelchair with a gait belt fastened around his waist and the chair. The DON stated the gait belt should not be there and the resident did not have an order for restraints. The DON stated the resident is not able to release the gait belt himself with how it was fastened behind the back of the wheelchair. The DON stated there is a risk of entrapment. During an interview on 12/15/2025 at 3:37 p.m. with Registered Nurse (RN) 2, RN 2 stated there is no informed consent or care plan for Resident 5 to have a lap belt or restraint. RN 2 stated having the gait belt around the resident's lap could cause him to get hurt, there is a risk of entrapment, and the gait belt could stop Resident 5 from moving as he normally does. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, last revised on 10/8/2025, the P&P indicated the following:1. Restraints should only be used for the safety and well-being of the resident and only after other alternatives have been tried unsuccessfully.2. A physical restraint includes equipment attached or adjacent to a resident's body that the resident cannot remove easily which restricts freedom of movement or normal access to one's body. 3. Restraints will only be used upon the written order of a physician and after obtaining consent from the resident or the resident's responsible party.

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	12/18/2025

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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to conduct an accurate Minimum Data Set (MDS - a standardized assessment and care screening tool) assessments for one (Resident 13) of five sampled residents by failing to ensure Resident 13's MDS reflect the resident's all current diagnoses. The failure resulted in not providing an accurate clinical overview of Resident 13's health status, which could have resulted in issues related to resident safety, quality of care and continuity of care.Findings: During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 8/5/2023 with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), muscle wasting and atrophy (loss of muscle tissue, mass, and strength), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), dementia (a progressive state of decline in mental abilities), and depression (a serious mood disorder causing persistent sadness, hopelessness, and loss of interest in activities). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 11/12/2025 indicated Resident 13's cognition (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) was moderately impaired. During review of Resident 13's physician order dated 8/5/2023, the order indicated Resident 13 was ordered to have Prozac (medication given to treat depression) oral capsule 20 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), 1 capsule by mouth one time a day for depression manifested by verbalization of sadness. During review of Resident 13's physician order, dated 12/4/2024, the order indicated Resident 13 was ordered to have Zyprexa (medication given to treat schizophrenia) oral tablet 2.5 mg, 1 tablet by mouth at bedtime for schizoaffective disorder manifested by talking to himself. During a review of Resident 13's care plan (CP) titled, Antidepressant, dated 8/12/2025, the CP indicated the resident has episodes of depression manifested by verbalization of sadness and has an order for Prozac 20 mg. During a review of Resident 13's CP titled, Antipsychotic, dated 8/12/2025, the CP indicated, the resident has episodes of schizoaffective disorder manifested by talking to himself and has an order for Zyprexa 2.5 mg. During a concurrent interview and record on 12/17/2025 at 4:55 PM with the Director of Nursing (DON), Resident 13's MDS: Section I - Active Diagnoses, dated 11/12/2025 was reviewed. The MDS did not indicate Resident 13's diagnoses of schizoaffective disorder and depression. The DON stated, both the diagnoses of depression and schizoaffective disorder should be listed on under Section I - Active Diagnoses but were not. The DON stated the MDS should indicate Resident 13's current diagnoses to ensure a complete and accurate overview of Resident 13's health status. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 10/8/2025, the P&P indicated, The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P also indicated, Documentation in the medical record will be objective . complete and accurate.

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	12/18/2025

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

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 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. Based on observation, interview, and record review the facility failed to ensure residents who were incontinent (lacks voluntary control over urination) of bladder (organ in the pelvis that stores urine) received appropriate treatment and services to prevent urinary tract infections (UTI, common infections that happen when bacteria infect the urinary tract) by failing to ensure the urinary catheter (a thin flexible tube that is inserted into the bladder to help drain urine) collection bag tubing was not looped or coiled to allow the urine to flow freely into the collection bag for one of two residents (Resident 62) reviewed under the urinary catheter care area.This failure had the potential to result in the backflow of urine into the resident's bladders, which can cause urinary tract infections (UTI- an infection in the bladder/urinary tract). Findings: During a review of Resident 62's admission Record, the admission Record indicated, the facility initially admitted Resident 62 to the facility on 4/3/2024 and readmitted the resident on 12/14/2025 with diagnoses including metabolic encephalopathy (a brain disorder causing confusion, memory loss, and loss of consciousness), congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and hypertensive heart disease (heart problems from long-term high blood pressure). During a review of Resident 62's Minimum Data Set (MDS - a resident assessment tool), dated 10/16/2025, the MDS indicated Resident 62's cognition was moderately impaired. The Bladder and Bowel section of the MDS indicated Resident 62 was using an indwelling urinary catheter appliance. During a review of Resident 62's Care Plan (CP) dated 12/14/2025, the CP indicated, Resident 62 has a Foley [specific brand of indwelling urinary catheter] catheter for acute urinary retention (sudden, painful inability to urinate despite a full bladder). The goal of the CP is for the bladder to be emptied without any complications of bladder distention, pain/discomfort and no signs and symptoms of bladder infection for three months. The interventions include maintaining unobstructed (not blocked) urine flow by maintaining patency (state of being open) of tubing and drainage by gravity. During a review of Resident 62's Physician Orders, the Physician Orders indicated an order dated 12/14/2025 for a Foley Catheter French (Fr - a unit of measurement in millimeters for the outer diameter of a catheter) 24/30 milliliter (ml - a unit of measurement for fluid volume) to gravity drainage. During a concurrent observation and interview on 12/15/2025 at 12:42 PM with Registered Nurse 1 (RN 1), in the resident dining room, Resident 62's urinary catheter tubing was looped preventing the free flow of urine through the tubing and into the collection bag. RN 1 stated, she observed the urinary catheter's tubing to be looped, not allowing the urine to flow freely into the collection bag. RN 1 adjusted Resident 62's collection bag to allow the tubing to uncoil and the urine to flow into the collection bag. RN 1 stated, if the urine had backed up into Resident 13's bladder, it could have caused a UTI. During an interview on 12/16/2025 at 3:35 PM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated, it is important to never allow a urinary catheter tubing to be looped because urine can back up inside the tubing and into the resident's bladder and cause an infection. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated 10/8/2025, the P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The policy also indicated, to maintain unobstructed urine flow, keep the catheter and tubing free of kinks and to position the drainage bag lower than the bladder at all times to prevent urine from flowing back int to the urinary bladder.

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	12/18/2025

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

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 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, interview and record review, the facility failed to implement appropriate infection control practices for two of 18 sampled residents (Resident 12 and Resident 18) by failing to: a. Ensure Resident 12's foam bed rail padding could be properly cleaned and disinfected. This failure had the potential to result in Resident 12 to come into contact with infectious pathogens (a biological agent, like a virus, bacterium, fungus, or parasite, that can cause illness) and acquire an infection due to lack of adequate disinfection of the surrounding environment. b. Ensure intravenous access (IV, a medical technique that administers fluids and medications directly into a person's vein) dressing was labeled with the insertion date. This failure placed Resident 60 at risk for developing complications such as inflammation of the vein and bloodstream infections because without a date staff may not be able to track how long the IV has been in.Findings: a. During a review of Resident 12's admission Record, the admission Record indicated, the facility initially admitted Resident 12 to the facility on [DATE] and readmitted the resident on 10/6/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), cardiomegaly (enlarged heart), atherosclerotic heart disease (the buildup of fats, cholesterol and other substances in and on the artery walls), and diabetes mellitus Type 2 (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 12's Minimum Data Set (MDS – a resident assessment tool), dated 9/12/2025, the MDS indicated Resident 12's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. During a review of Resident 12's Side Rail Assessment, dated 9/12/2025, the assessment indicated, Resident 12 did not require the use of padded side rails. During a concurrent observation and interview on 12/15/2025 at 9:26 AM with Registered Nurse 1 (RN 1), in Resident 12's room, Resident 12's bedside rail was observed to have a deteriorated, black, porous foam material duct taped to the railing. RN 1 stated, the black, porous foam padding on his bedside rail was an infection control issue due to the foam falling apart and not being easily cleaned due to the foam material. RN 1 also stated, Resident 12 did not have any safety precautions that required the use of the bedside rail padding, which was left on the railing from a previous resident who occupied the bed prior to Resident 12. During an interview on 12/16/2025 at 3:48 PM with Head of Housekeeping (HH), the HH stated, on a daily basis, the facility's housekeeping staff disinfect all resident bedside rails and any black, porous foam padding that is on the railing with Clorox Bleach Germicidal Wipes. During a concurrent interview and record review on 12/16/2025 at 4:30 PM with the Infection Preventionist (IP), the Clorox Bleach Germicidal Wipes, dated 2024, manufacturer disinfection instructions were reviewed. The instructions indicated, the wipes are to be used To clean and disinfect and deodorize hard, nonporous surfaces. The IP stated that she understood the bedside rail padding being used was a black, porous foam material that is not suitable to be adequately cleaned by the Clorox Bleach Germicidal Wipes due to the porous nature. The IP stated the risk of not being able to clean the foam adequately is a risk for causing infection and illness. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of (continued on next page)

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	12/18/2025

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident-Care Items and Equipment, dated 10/8/2025, indicated, Non-critical items are those that come in contact with intact skin but not mucous membranes . Non-critical environmental surfaces include bed rails. The P&P also indicated, Non-critical items require cleaning followed by either low or intermediate-level disinfection following manufacturer's instructions. During a review of the facility's P&P titled, Policies and Practices – Infection Control, dated 10/8/2025, indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The P&P also indicated, the objectives of the facility's infection control policies and practices are to Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. b. During a review of Resident 60's admission Record, the admission Record indicated the facility admitted the resident on 3/14/2025 with diagnoses that included chronic kidney disease (the kidneys are damaged and can't filter blood well over time). During a review of Resident 60's MDS, dated [DATE], the MDS indicated Resident 60 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 60 required setup assistance (helper sets up and resident completes the activity) with eating. During a review of Resident 60's Physician's Orders, dated 12/11/2025, the orders indicated the following:- Monitor IV site for signs/symptoms of infiltration (fluid that accumulates where it does not belong, i.e. IV fluid outside a vein) or phlebitis (inflammation of a vein, often appearing as redness, pain, warmth, and swelling), dated 12/11/2025.- Ertapenem Sodium Injection Solution (an antibiotic medication to treat infections), 500 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) intravenously one time a day for pneumonia (an infection/inflammation in the lungs) for five days, dated 12/11/2025. During a review of Resident 60's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 12/2025, the MAR indicated Resident 60 received ertapenem daily from 12/11/2025 until 12/15/2025. During a review of Resident 60's IV Antibiotic Therapy Care Plan (CP), initiated 12/11/2025, the CP indicated Resident 60 needs IV therapy for an antibiotic medication (a medication given to fight a bacterial infection). The care plan indicated a goal that Resident 60 will not have any signs or symptoms of infection following IV antibiotic therapy. The care plan indicated an intervention to monitor IV site for any signs/symptoms of infection or infiltration every shift. During a concurrent interview and observation with the Director of Staff Development (DSD) on 12/15/2025 at 9:35 a.m., observed Resident 60's left hand IV that was unlabeled with an insertion date. The DSD stated she was not sure how long Resident 60 had the left hand IV but would find out when it was placed. During a concurrent interview and record review with the Infection Preventionist (IP) on 12/15/2025 at 9:41 a.m., the IP stated she administered an IV antibiotic medication to Resident 60 earlier that morning, approximately 8:50 a.m. The IP reviewed the IV MAR and nursing progress notes. The IP concluded that there was no documentation of the date/time Resident 60's IV was started. The IP stated she was not sure how long the left hand IV was there, but she had given the medication on (continued on next page)

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	12/18/2025

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/12/2025 when Resident 60 had a right upper arm IV. The IP stated Resident 60's left hand IV must have been started on the weekend but was not sure which day. The IP stated the practice is to label an IV with the date/time it was started and to document in the resident's MAR. The IP stated it was important to do this to know how long the IV is present to not keep them too long because that could put residents at risk for infection. During an interview with the Director of Nursing (DON) on 12/16/2025 at 4:21 p.m., the DON stated the practice is to label the IV site on the resident with a start date and to document in the resident's chart the location, start date, and time so the licensed nurses will know how long to keep before changing. The DON stated the licensed nurses should document the date/time the IV was started on the dressing and document in Resident 60's MAR. The DON stated this is important to ensure the IV is present for a duration of less than four days, per policy, because that could be a potential for infection if left longer. During a review of the facility's policy and procedure (P&P) titled, Peripheral IV Catheter and Site Selection, last reviewed 10/08/2025, the P&P indicated the following:- Select peripheral intravenous catheters (PIVCs) based on prescribed therapies, duration of treatments, availability of peripheral access sites, diagnosis, and potential complications.- Use PIVCs for duration of less than four days when criteria is met for compatibility of therapy. - The licensed nurses are to document the following upon catheter insertion: the location and vein of the insertion and the rationale for selection. During a review of the facility's policy and procedure titled, Charting and Documentation, last reviewed 10/08/2025, the P&P indicated the following:Documentation of procedures and treatments will include care-specific details, including:- The date and time the procedure/treatment was provided.- The name and title of the individual(s) who provided the care.- The assessment data.- How the resident tolerated the procedure.

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	12/18/2025

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

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet the requirement of 80 square feet (sq. ft., a unit of measure) per resident in multiple resident bedrooms for 27 of 28 resident rooms (room [ROOM NUMBER], 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 21, 23, 24, 25, 26, 27, 28, 29, and 30). This deficient practice had the potential to result in inadequate space for safe nursing care and privacy for the residents.Findings:On 12/18/2025, the Administrator (ADM) submitted the Client Accommodation Analysis Form (a form designed to provide a record of resident accommodations approved for licensed care) and the facility letter requesting for continuation of its room size waiver.During a review of the Client Accommodation Analysis submitted by the Administrator on 12/18/2025, the analysis sheet indicated the rooms and space measurements were as follows: Room No. Room Size (SF: Square Feet) Beds SF per resident1 148.05 2 74 2 154.63 2 77.33 154.63 2 77.34 151.34 2 75.65 145.81 2 72.96 149.10 2 74.57 214.65 3 71.58 214.65 3 71.59 218.61 3 72.810 218.61 3 72.811 218.61 3 72.8 12 221.87 3 73.9 14 217.7 3 72.515 217.7 3 72.516 217.7 3 72.517 217.7 3 72.518 217.7 3 72.519 214.65 3 71.521 217.7 3 72.523 149.24 2 74.624 149.24 2 74.625 147.15 2 73.5 26 143.88 2 71.927 143.88 2 71.928 143.88 2 71.929 145.97 2 72.9 30 142.70 2 71.3 During a review of the letter from the Administrator regarding a request for room size waiver, dated 12/22/2025, the letter indicated a request for a continuing waiver for room [ROOM NUMBER], 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 21, 23, 24, 25, 26, 27, 28, 29, and 30. The waiver letter indicated there is still enough space to provide for each resident's care, dignity, and privacy. The rooms are in accordance with the special needs of residents and will not have an adverse effect on the residents' health and safety or impede the ability of any resident in the room to attain his or her highest practicable well-being. During an observation on 12/15/2025 at 11:30 a.m., during a general observation of room [ROOM NUMBER], both residents and staff had enough space to move about freely inside the rooms. Throughout the survey, the survey team observed there to be enough space for residents and staff to move about freely inside the rooms. The nursing staff had enough space to safely provide care to the residents with space for the beds, side tables, dressers, and resident care equipment. Residents who were in these rooms with limited size were not adversely affected.During a follow-up interview with the ADM on 12/18/2025 at 10 a.m., the ADM stated there should be at least 80 square feet per resident in multiple resident rooms. The minimum requirement for two residents (two beds) in a room should be at least 160 square feet and for three residents (three beds) in a room should be at least 240 square feet.