STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555765	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Post Acute	1800 Old Tustin Avenue Santa Ana, CA 92705

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 - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50126 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services for one of four sampledresidents (Resident 1). * The facility failed to ensure Resident 1's oxycodone medications (narcotic/pain medications) were stored properly that resulted in the missing medications. * The facility failed to ensure Resident 1's Controlled Drug record and the MAR documentation for oxycodone matched. * The facility failed to ensure the proper inventory of all narcotics during the incoming and outgoing shift changes for the licensed nurses assigned to Medication Carts 1, 2, 3, and 5. These failures had the potential for diversion of the controlled medications and possible health complications due to not administering the medications as prescribed. Findings: Review of the facility's P&P titled Medication Ordering and Receiving from Pharmacy revised 9/2019 showed only the licensed personnel may receive the controlled substances from the pharmacy driver/courier. a. A nurse signs for the medications, including the controlled substances, on the pharmacy delivery ticket and inspects the medications. b. The receiving nurse transfers medications and accompanying inventory sheets to an authorized nurse on the unit (if different than the nurse who received the medication). c. Two nurses witness placement of the controlled substances in the secured compartment of the medication cart. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Medication Storage in the Facility revised 8/2019 showed Scheduled (II-IV) medications (narcotic medications) and other medications subject to abuse or diversion are stored in a permanently affixed, locked compartment separate from all other medications. Alternatively, in a unit dose system, these medications may be kept with other medications in the cart if the supply of medications is minimal and the shortage is readily detectable. The access system to controlled medications is not the same as the system giving access to other medications (the key that opens the compartment is different from the key that opens the medication cart). If a key system is used, the medication nurse on duty maintains possession of the key to controlled substance storage areas. Back-up keys to all medication storage areas, including those for controlled substance are kept by the director of nursing or designee. Medical record review for Resident 1 was initiated on 5/2/24. Resident 1 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 1's Order Summary Report as of 2/29/24, showed a physician's order dated 1/25/24, to administer oxycodone 10 mg one tablet by mouth every 24 hours as needed for pain. Review of Resident 1's Order Summary Report as of 4/30/24, showed a physician's order dated 4/22/24, to administer oxycodone 5 mg one tablet by mouth every 24 hours as needed for pain. 1. Review of the facility's SOC 341 dated 4/29/24, showed the facility reported a suspected drug discrepancy and the medications for Resident 1 remained unaccounted for. On 5/2/24 at 1130 hours, an interview and concurrent facility document review was conducted with the DON. The following pharmacy documents were reviewed and verified by the DON: - A telephone order dated 4/11/24 at 2241 hours, showed the facility ordered Resident 1's oxycodone medications. - Consolidated Delivery Sheets dated 4/17/24 at 1600 hours, showed the facility received 30 tablets of oxycodone 10 mg for Resident 1. On 5/3/24 at 1224 hours, a telephone interview was conducted with RN 1. When asked about Resident 1's oxycodone medication delivered on 4/17/24, RN 1 acknowledged signing and receiving Resident 1's 30 tablets of oxycodone 10 mg. RN 1 stated after receiving the medications, the medications were placed inside the IV medication cart. RN 1 further stated he did not tell anyone about Resident 1's oxycodone medication inside the IV medication cart and did not recall what happened to the medication after putting it inside the IV medication cart. On 5/3/24 at 1345 hours, an interview was conducted with the Administrator. The Administrator acknowledged and was aware of RN 1 signing and receiving the oxycodone medications for Resident 1. On 5/3/24 at 1415 hours, a telephone interview was conducted with LVN 2. LVN 2 stated she followed up on Resident 1's oxycodone medication on 4/22/24. LVN 2 further stated the pharmacy made her aware RN 1 had signed and received Resident 1's oxycodone medication on 4/17/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/3/24 at 1430 hours, an interview was conducted with the Clinical Resource nurse. The Clinical Resource nurse verified LVN 2 made her aware of the missing oxycodone medications for Resident 1 on 4/22/24. The Clinical Resource nurse acknowledged and verified Resident 1's 30 tablets of oxycodone 10 mg medications were missing. 2. Review of the facility's P&P titled Preparation and General Guidelines revised 10/2019 showed when a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record/and or the medication administration record (MAR): 1. Date and time od administration. 2. Amount administered. 3. Remaining quantity. 4. Signature of the nurse administering the dose on the accountability record at the time the medication is removed from supply. 5. Initials of the nurse administering the dose, completed after the medication is administered. Review of Resident 1's Internal Medicine H&P examination dated 1/24/24, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's Controlled Drug Record for oxycodone 10 mg tablets and MARs for February and March 2024 showed the oxycodone 10 mg tablets were signed out from the controlled drug records on 2/5/24 at 2204 hours, 3/19/24 at 2130 hours, and 3/25/24 at 2350 hours. However, review of the MARs for February and March 2024 did not show the oxycodone 10 mg medications were administered on 2/5, 3/19, and 3/25/24. Review of Resident 1's Controlled Drug Record for oxycodone 5 mg tablet and MAR for May 2024 showed the oxycodone 5 mg tablet was signed out from the controlled drug records on 5/1/24 at 2330 hours. However, the review of the MAR for May 25024 showed the oxycodone 5 mg medication was not administered on 5/1/24. On 5/2/24 at 1100 hours, an interview and concurrent review of Resident 1's Controlled Drug Records and MARs for February to May 2024 were conducted with LVN 3. LVN 3 was made aware of Resident 1's oxycodone medication MARs and control drug records did not match. LVN 3 verified the findings. On 5/2/24 at 1120 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated if a narcotic medication was administered,it should be documented in the MARs and controlled drug records, and both of those documents should match. 3. Review of the facility's P&P titled Medication Storage in the Facility revised 8/2019 showed the following: - at each shift change, or when keys are transferred a physical inventory of all controlled substances including the emergency supply is conducted by two licensed nurses and is documented; and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the DON in conjunction with the Pharmacy Consultant or designee routinely monitors the controlled substance storage, records (i.e., change of shift sheets, individual controlled substance accountability sheets, MARs, delivery confirmation sheets), and expiration dates during their monthly medication storage inspections. a. On 5/3/24 at 0745 hours, review of Medication Cart 3 Narcotic Binder was conducted with LVN 3. Review of the Shift Count sheets for the controlled drug showed themissing outgoing and/or incoming licensed nurses' signatures for the following dates: - On 1/27 and 1/29/24; - On 2/3, 2/4, 2/10, 2/11, 2/12, 2/17, 2/26, 2/27, 2/28, and 2/29/24; - On 3/2, 3/12, 3/15, 3/17, 3/27, and 3/23/24; and - On 4/14, and 4/28/24. On 5/3/24 at 0829 hours, LVN 3 verified the missing signatures for the controlled drugs shift count in the controlled substance binder for Medication Cart 3. On 5/3/24 at 0900 hours, an interview and concurrent facility document review was conducted with the DON and Clinical Resource nurse. The DON and Clinical Resource nurse were made aware of the findings and verified the missing signatures during the shift counts for Medication Cart 3. b. Review of Medication Cart 1's Narcotic Binder showed the Shift Count sheets with the missing licensed nurses' signatures on the following dates and shifts: - On 3/25/24, during the PM shift, there were no incoming and outgoing signatures; - On 4/6/, 4/7, 4/8, 4/9, 4/11, 4/16, and 4/21/24, during the PM shifts, there were no outgoing signatures; and - On 3/25, 3/26, 4/1, 4/7, 4/9, and 4/12/24, during the Noc shifts, there were no outgoing signatures. On 5/02/24 at 1654 hours, an interview and concurrent facility document review was conducted with LVN 6. LVN 6 verified for those multiple missing licensed nurses' signatures in the Shift Count sheets in the narcotic binder. LVN 6 was asked what the Shift Count narcotic sheet was for. LVN 6 stated it wasfor the outgoing and incoming shifts nurses to count the narcotic medications at the end of the shifts to make sure the narcotic medication counts were properly reconciled to prevent possible diversion of the medications. LVN 6 further stated after the count was confirmed, the incoming and outgoing nurses must sign the shift count sheets in the narcotic binder, and it should be done every end and start of each shift. c. Review of Medication Cart 5's Narcotic Binder showed the Shift Count sheets with the missing licensed nurses'signatures on the following dates and shifts: - On 3/24/24, during the AM shift, there was no incoming signature; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/24 and 4/27/24, during the PM shifts, there were no incoming and outgoing signatures; - On 3/27 and 4/9/24, during the PM shifts, there were no outgoing signatures; and - On 4/23 and 4/27/24, during the Noc shifts, there were no outgoing signatures; On 5/3/24 at 0947 hours, an interview and concurrent facility document review was conducted with LVN 7. LVN 7 verified there were missing signatures on different days and shifts on the narcotics Shift Count sheet. LVN 7 was asked what the narcotics count sheet was for. LVN 7 stated the outgoing and incoming shifts nurses werecounting the narcotic medications at the end of the shifts to ensure the narcotic medication counts were reconciled properly to prevent possible diversion of the medications. LVN 7 further stated once the count was confirmed, both the incoming and outgoing nurses should sign the shift count sheets in the narcotic binder. d. Review of the Medication Cart 2's Narcotic Binder showed the Shift Count sheet with the missing licensed nurses' signatures on the following dates and shifts: - On 3/16 and 4/14/24, during the AM shifts, there were no outgoing signatures; - on 3/16 and 4/25/24, during the 3-11 shifts, there was no outgoing signature; and - on 2/25, 3/16, 3/25, 3/27, 4/1, and 4/14/24, during the Noc shifts, there were no outgoing signatures. On 5/3/24 at 1015 hours, an interview and concurrent facility documentreview was conducted with the DON. The DON verified there were multiple missing licensed nurses' signatures on the narcotic shift count sheets. The DON further stated the licensed nurses should have no missing documentation on each of the daily shift counts. On 5/3/24 at 1045 hours, a follow-up interview and concurrent facility document review was conducted with the DON. The DON verified the findings on the Shift Count sheets in the narcotic binder with multiple missing licensed nurses' signatures for Medication Carts 1, 2, and 5.