

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555765	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER The Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882</p> <p>Based on interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for three of eight sampled residents (Residents 2, 3, and 8) were complete and accurate.</p> <p>* The facility failed to ensure the licensed nurse documented the blood sugar levels and medications administered to Resident 2 in the MAR.</p> <p>* The facility failed to ensure the licensed nurse documented the blood sugar levels and insulin medication administered to Resident 3 in the MAR.</p> <p>* The facility failed to ensure the licensed nurse documented the initials in the MAR when Resident 8's medications were administered.</p> <p>These failures had the potential for the residents' care needs not being met as their medical information were inaccurate and incomplete.</p> <p>Findings:</p> <p>Review of the facility's P&P titled Specific Medication Administration Procedures dated 10/2019, showed to obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration; and after the administration of medication, return to the cart, replace medication container, and document the administration in the MAR or TAR.</p> <p>Review of the facility's P&P titled Obtaining a Fingertick Glucose Level (undated) under the section for Documentation showed the person performing this procedure should record the following information in the resident's medical record:</p> <ul style="list-style-type: none"> - the date and time the procedure was performed, - the name and title of the individual who performed the procedure, - all assessment data obtained during the procedure, - how the resident tolerated the procedure, <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- if the resident refused the procedure, the reason(s) why and the intervention taken,</p> <p>- the blood sugar results. To follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results, and</p> <p>- the signature and title of the person recording the data.</p> <p>1. Medical record review for Resident 2 was initiated on 6/24/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].</p> <p>Review of Resident 2's MAR for June 2024 showed the following medications were scheduled to be administered on 6/6 and 6/14/24, at 0630 hours:</p> <p>- levothyroxine sodium (a medication to treat hypothyroidism, an underactive thyroid) 75 mcg by mouth for low thyroid hormone</p> <p>- regular insulin human injection (a medication used to lower the blood sugar) to inject subcutaneously before meals and at bedtime as per sliding scale as follows:</p> <p>- BS less than 70 mg/dL, to follow the facility's protocol and notify the MD.</p> <p>- BS 0 - 150 mg/dL, give 0 (zero) units.</p> <p>- BS 151 - 200 mg/dL, give two units.</p> <p>- BS 201 - 250 mg/dL, give four units.</p> <p>- BS 251 - 300 mg/dL, give six units.</p> <p>- BS 301 - 350 mg/dL, give eight units.</p> <p>- BS 351 - 400 mg/dL, give 10 units.</p> <p>- BS greater than 400 mg/dL, give 12 units and notify MD.</p> <p>However, further review of Resident 2's MAR for June 2024 showed the spaces for the license nurse to document the blood sugar levels, levothyroxine administered, amount of the regular insulin administered, and licensed nurses' initials were blank on 6/6 and 6/14/24 at 0630 hours.</p> <p>On 6/24/24 at 1516 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON stated she expected the licensed nurses to document the administration of the medications in the MAR right after the medications were administered. The DON verified the above findings.</p> <p>On 6/25/24 at 1420 hours, the Administrator, DON, and DSD were informed and acknowledged the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Medical record review for Resident 3 was initiated on 6/24/24. Resident 3 was admitted to the facility on [DATE].</p> <p>Review of Resident 3's MAR for June 2024 showed the following medication was scheduled to be administered on 6/6 and 6/14/24 at 0630 hours:</p> <ul style="list-style-type: none"> - regular human insulin injections, subcutaneously before meals and at bedtime as per sliding scale as follows: - BS 150 - 200 mg/dL, give three units. - BS 201 - 250 mg/dL, give six units. - BS 251 - 300 mg/dL, give nine units. - BS 301 - 350 mg/dL, give 12 units. - BS 351 - 400 mg/dL, give 15 units. - BS greater than 400 mg/dL, to call the physician. <p>However, further review of Resident 3's MAR for June 2024 showed the spaces to document the blood sugar levels, amount of the insulin administered, and license nurses' initials were blank on 6/6 and 6/14/24 at 0630 hours.</p> <p>On 6/24/24 at 1516 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON stated she expected the licensed nurses to document the administration of the medications in the MAR right after the medications were administered. The DON verified the above findings.</p> <p>On 6/25/24 at 1420 hours, the Administrator, DON, and DSD were informed and acknowledged the above findings.</p> <p>3. Medical record review for Resident 8 was initiated on 6/24/24. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 8 had a diagnosis of Parkinsonism.</p> <p>Review of Resident 8's Order Summary Report showed the physician order to administer the following medications:</p> <ul style="list-style-type: none"> - amantadine hcl (a medication used to treat Parkinson's disease) 100 mg capsule, one capsule by mouth in the morning for antiparkinson, ordered on 2/28/24; - entacapone (a medication used to treat Parkinson's disease) 200 mg tablet, half a tablet by mouth every four hours for parkinsons, ordered on 3/5/24; and - carbidopa-levodopa (a medication used to treat Parkinson's disease) 25-100 mg table, 1.5 tablets by mouth every four hours for parkinsons, ordered on 3/5/24. <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 8's MAR for June 2024 showed to administer the following medications on 6/14/24, as scheduled:</p> <ul style="list-style-type: none"> - entacapone tablet 200 mg, half a tablet by mouth and carbidopa-levodopa oral tablet 25-100 mg, to give 1.5 tablets by mouth at 0100 and 0500 hours; and - amantadine hcl oral capsule 100 mg at 0630 hours. <p>Review of Resident 8's MAR for June 2024 showed to administer the following medications on 6/16/24, as scheduled:</p> <ul style="list-style-type: none"> - entacapone tablet 200 mg, half a tablet by mouth and carbidopa-levodopa oral tablet 25-100 mg, to give 1.5 tablets by mouth at 0500 hours; and - amantadine hcl oral capsule 100 mg at 0630 hours. <p>However, further review of Resident 8's MAR for June 2024 showed the spaces for the licensed nurses' initials for medication administration were blank for the above scheduled medications on 6/14 and 6/16/24.</p> <p>On 6/24/24 at 1516 hours, an interview was conducted with the DON. The DON stated she expected the licensed nurses to document the administration of the medications in the MAR right after the medications were administered.</p> <p>On 6/25/24 at 1129 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON verified the above findings.</p> <p>On 6/25/24 at 1420 hours, the Administrator, DON, and DSD were informed and acknowledged the above findings.</p>