Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

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	07/17/2024

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 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36872 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of three sampled residents (Resident 3) received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. * Resident 3 had an unwitnessed fall with injury to his head. There were no details of skin documentation after Resident 3's fall. This failure had the potential to negatively affect the resident's health and well-being. Findings: Review of the facility's P&P titled Fall Management System (undated) showed when a resident sustains a fall, a physical assessment will be completed by a licensed nurse with the results documented in the Nursing Progress Notes. The follow-up assessment and documentation will be conducted for a minimum of 72 hours following the incident. On 7/15/24 at 1345 hours, an observation and concurrent interview was conducted with Resident 3. Resident 3 was observed lying in his bed. Resident 3 stated he had a pain level of 8 (on a 0-10 pain scale with 0 = no pain and 10 = worst pain) to his head and pointed to his right frontal temporal. A round bump with a tiny dry scab on Resident 3's head was observed, measuring approximately 2.5 cm (length) x 2.5 cm (width). Resident 3 stated he had an unwitnessed fall last week and was transferred to the acute care hospital. Resident 3 stated the injury on his head was twice as big before compared to now. Medical record review for Resident 3 was initiated on 7/15/24. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 5/1/24, showed Resident 3 had the capacity to understand and make decisions. (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 0684 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 3's Nurse Progress Note dated 7/7/24 at 0015 hours, showed the resident's vital signs were documented as follows: BP - 119/82 mmHg, P - 114 beats per minute, RR - 15 breaths per minute, O2 - 98% at room air, and T - 98.0 degrees F. Upon assessment, Resident 3 was noted with hematoma on the right side of his head. Resident 3 stated on 7/6/24 at 1030 hours, on the previous shift, he attempted to use his walker in the hallway of his bedroom, fell and hit his head on the ground, bumped his right hip, and attempted to break his fall hurting both wrists. The opened wound was noted to the right side of his head with scant amount of blood. No deformity of the wrist was noted. No ecchymosis or redness area was noted to the hip area. Review of Resident 3's interact Transfer Form showed the resident was transferred to the acute care hospital due to a fall. There was no documentation regarding Resident 3's skin/wound. Review of Resident 3's Emergency Department Record dated 7/7/24, showed the resident sustained a hematoma, measuring approximately 2 cm x 1 cm to the right frontal temporal region with a sub-1 cm superficial abrasion. Review of Resident 3's Nurse Progress Note dated 7/7/24 at 0419 hours, showed Resident 3 would be sent back to the facility around 0530 hours. Resident 3 had a scan performed at which showed only normal findings. Resident 3 was stable with a right forehead hematoma. Review of Resident 3's Condition Follow up Nurse Progress notes dated 7/7/24 at 1409 hours, showed Resident 3 was on monitoring for status post fall. However, there was no documentation about the description of the hematoma on the right frontal temporal. On 7/16/24 at 1133 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The DON acknowledged the staff should document the description of the hematoma.