

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 10/29/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41941</p> <p>Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to safeguard the controlled medications for nine of 11 sampled residents (Residents 3, 4, 5, 6, 7, 8, 9, 10, and 11) as evidenced by:</p> <ul style="list-style-type: none"> * 116 tablets of tramadol (a controlled pain medication used to treat moderate to severe pain) 50 mg for Resident 3 were missing from the medication cart's locked narcotic drawer. * 39 tablets of hydrocodone-acetaminophen (a controlled pain medication made up of an opioid and a mild analgesic) 5 mg/325 mg for Resident 4 were missing from the medication cart's locked narcotic drawer. * 60 tablets of tramadol 50 mg for Resident 5 were missing from the medication cart's locked narcotic drawer. * 15 tables of Oxycontin (generic name is oxycodone, a controlled pain medication used to treat severe ongoing pain) 10 mg for Resident 6 were missing from the medication cart's locked narcotic drawer. * 87 tables of hydrocodone-acetaminophen 10 mg/325 mg for Resident 7 were missing from the medication cart's locked narcotic drawer. * 60 tablets of tramadol 50 mg for Resident 8 were missing from the medication cart's locked narcotic drawer. * 24 tablets of tramadol 50 mg for Resident 9 were missing from the medication cart's locked narcotic drawer. * 48 tablets of tramadol 50 mg for Resident 10 were missing from the medication cart's locked narcotic drawer. * 84 tablets of tramadol 50 mg for Resident 11 were missing from the medication cart's locked narcotic drawer. <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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>These failures resulted in the diversion of the controlled medications for Residents 3, 4, 5, 6, 7, 8, 9, 10, and 11, which had the potential to negatively impact the residents.</p> <p>Findings:</p> <p>According to the Drug Enforcement Administrator (DEA), the drugs are classified as controlled substances according to their actual or potential for abuse and their risk to the public health.</p> <p>Review of the facility's P&P titled Disposal of Medications and Medication - Related Supplies revised , d+[DATE] showed medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. The P&P also showed the medications must be obtained from a locked cabinet or secure storage. Additionally, the P&P showed when a dose of a controlled medication is wasted, it must be destroyed in the presence of two licensed nurses and documented on the accountability record/book.</p> <p>On [DATE], the CDPH, L&C Program received the SOC 341 form from the facility showing Resident 3's medications were allegedly unaccounted for on [DATE].</p> <p>Review of the facility's 5-Day Investigation Report submitted on [DATE], showed the following controlled medications were missing:</p> <ul style="list-style-type: none"> - tramadol 50 mg medication bubble pack containing 116 tablets for Resident 3; - hydrocodone-acetaminophen ,d+[DATE] mg medication bubble pack for Resident 4; - tramadol 50 mg medication bubble pack for Resident 5; - Oxycontin 10 mg medication bubble pack for Resident 6; - hydrocodone-acetaminophen ,d+[DATE] mg medication bubble pack for Resident 7; - tramadol 50 mg medication bubble pack for Resident 8; and - tramadol 50 mg medication bubble pack for Resident 10. <p>a. Medical record review for Resident 3 was initiated on [DATE]. Resident 3 was admitted to the facility on [DATE].</p> <p>Review of Resident 3's H&P examination dated [DATE], showed Resident 3 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 3's MDS dated [DATE], showed Resident 3 had moderate cognitive impairment.</p> <p>Review of Resident 3's Order Summary Report showed a physician's order dated [DATE], to administer tramadol 50 mg one tablet by mouth every six hours as needed for moderate to severe pain.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 3's controlled medication log showed 116 tablets of tramadol medication were received on [DATE]. The controlled medication log also showed a line drawn across the page with Returned to DON written above the line and dated [DATE]. Two signatures were observed underneath the line.</p> <p>b. Medical record review for Resident 4 was initiated on [DATE]. Resident 4 was admitted to the facility on [DATE].</p> <p>Review of Resident 4's H&P examination dated [DATE], showed Resident 4 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 4's MDS dated [DATE], showed Resident 4 was cognitively intact.</p> <p>Review of Resident 4's Order Summary Report showed a physician's order dated [DATE], to administer hydrocodone-acetaminophen 5 mg/325 mg one tablet every four hours as needed for moderate pain.</p> <p>Review of Resident 4's controlled medication log showed 42 tablets of hydrocodone-acetaminophen 5 mg/325 mg were received on [DATE]. Review of Resident 4's controlled medication log also showed the amount of tablets remaining in the bubble pack on [DATE] was 39 tablets. The controlled medication log showed a line drawn across the page with Transfer to DON written above the line and dated [DATE]. Two initials were observed underneath the line.</p> <p>c. Medical record review for Resident 5 was initiated on [DATE]. Resident 5 was admitted to the facility on [DATE].</p> <p>Review of Resident 5's H&P examination dated [DATE], showed Resident 5 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 5's MDS dated [DATE], showed Resident 5 was cognitively intact.</p> <p>Review of Resident 5's Order Summary Report showed a physician's order dated [DATE], to administer tramadol 50 mg one tablet by mouth every 12 hours as needed for breakthrough moderate to severe pain.</p> <p>Review of Resident 5's controlled medication log showed 60 tablets of tramadol 50mg were received on [DATE]. The controlled medication log showed a line drawn across the page with Transferred to DON written above the line and dated [DATE]. Two initials were observed underneath the line.</p> <p>d. Medical record review for Resident 6 was initiated on [DATE]. Resident 6 was admitted to the facility on [DATE].</p> <p>Review of Resident 6's H&P examination dated [DATE], showed Resident 5 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 6's MDS dated [DATE], showed Resident 6 was cognitively intact.</p> <p>Review of Resident 6's Order Summary Report showed the following physician's orders dated [DATE], to administer oxycodone HCl 5 mg one tablet by mouth every six hours as needed for moderate to severe pain and to administer oxycodone HCl 5 mg one tablet two times a day for pain management.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 6's controlled medication log showed there were 15 tablets of Oxycontin 10mg remaining in the bubble pack on [DATE]. The controlled medication log showed a line drawn across the page with Transfer to DON written above the line and the date was illegible. Two initials were observed underneath the line.</p> <p>e. Closed medical record review for Resident 7 was initiated on [DATE]. Resident 7 was admitted to the facility on [DATE], and had expired on [DATE].</p> <p>Review of Resident 7's MDS dated [DATE], showed Resident 7 was cognitively intact.</p> <p>Review of Resident 7's controlled medication log showed a physician's order for hydrocodone-acetaminophen 10 mg/325 mg one tablet every four hours as needed for moderate to severe pain. The controlled medication log showed there were 87 tablets of hydrocodone-acetaminophen remaining in the bubble pack on [DATE]. In addition, Resident 7's controlled medication log showed a line drawn across the page with Transferred to DON written above the line and the date was illegible Two initials were observed underneath the line.</p> <p>f. Closed medical record review for Resident 8 was initiated on [DATE]. Resident 8 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Review of Resident 8's H&P examination dated [DATE], showed Resident 8 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 8's Medication Administration Record (MAR) for [DATE] showed a physician's order dated [DATE], to administer tramadol 50 mg one tablet by mouth every 8 hours as needed for mild to severe pain for 3 days only. Further review of Resident 8's MAR showed the tramadol medication was not administered.</p> <p>Review of Resident 8's controlled medication log showed there were 60 tablets of tramadol 50 mg tablets remaining in the bubble pack on [DATE]. The controlled medication log also showed a line drawn across the page with Transfer to DON written above the line and the date was illegible. Two initials were observed underneath the line.</p> <p>g. Closed medical record review for Resident 9 was initiated on [DATE]. Resident 9 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>Review of Resident 9's H&P examination dated [DATE], showed Resident 9 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 9's MDS dated [DATE], showed Resident 9 was cognitively intact.</p> <p>Review of Resident 9's controlled medication log showed there were 24 tablets of tramadol 50 mg remaining in the bubble pack. The controlled medication log also showed a line drawn across the page with Returned to DON written and two initials underneath the line.</p> <p>h. Closed medical record review for Resident 10 was initiated on [DATE]. Resident 10 was admitted to the facility on [DATE], and discharged on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 10's H&P examination dated [DATE], showed Resident 10 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 10's MDS dated [DATE], showed Resident 10 was cognitively intact.</p> <p>Review of Resident 10's Order Summary Report showed a physician's order dated [DATE], to administer tramadol 50 mg one tablet by mouth every six hours as needed for moderate pain and two tablets every six hours as needed for severe pain.</p> <p>Review of Resident 10's controlled medication log showed there were 48 tablets of tramadol 50 mg remaining in the bubble pack. The controlled medication log also showed a line drawn across the page with Transferred to DON written above the line and dated [DATE]. Two initials were observed underneath the line.</p> <p>i. Closed medical record review for Resident 11 was initiated on [DATE]. Resident 11 was admitted to the facility on [DATE] and discharged on [DATE].</p> <p>Review of Resident 11's H&P examination dated [DATE], showed Resident 11 had the capacity to understand and make medical decisions.</p> <p>Review of Resident 11's MDS dated [DATE], showed the resident had moderate cognitive impairment.</p> <p>Review of Resident 11's Order Summary Report showed a physician's order dated [DATE], to administer tramadol 50 mg one tablet by mouth every four hours as needed for moderate pain.</p> <p>Review of Resident 11's controlled medication log showed there were 84 tablets of tramadol 50 mg remaining in the bubble pack on [DATE]. The controlled medication log also showed a line drawn across the page with Transferred to DON written above the line and dated [DATE].</p> <p>On [DATE] at 1315 hours, an interview and concurrent facility document review was conducted with the DON and Administrator. The DON stated when a controlled medication was discontinued or a resident was transferred out of the facility, the controlled medication was transferred from the medication carts to the DON's locked cabinets. The DON stated the controlled medication logbook, to which the facility referred as the blue book was where they kept a record of the delivery, administration, and removal of the controlled medications from the medication carts. The DON stated both the controlled medications and blue book were kept locked in the medication carts. The DON stated when a controlled medication was transferred to her, a line was drawn across the page with the words transferred to DON or returned to DON written next to the line. The DON stated the licensed nurse signing over the controlled medications to the DON and the nurse witnessing the transfer would initial the transaction. The DON stated on [DATE] at around 1200 hours, RN 1 attempted to obtain the tramadol medication from Resident 3's bubble pack, but there was no tramadol available in the medication cart's locked narcotic drawer. RN 1 then reviewed the bluebook and noted the tramadol had been transferred to the DON for destruction. RN 1 then contacted the DON regarding the missing tramadol medication for Resident 3. The DON stated the signature on the controlled medication log for Resident 3's tramadol was forged. The DON verified the following controlled medications were missing:</p> <p>- 116 tablets of tramadol 50 mg for Resident 3;</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - 39 tablets of hydrocodone-acetaminophen 5 mg/325 mg for Resident 4; - 60 tablets of tramadol 50 mg for Resident 5; - 15 tablets of Oxycontin 10 mg for Resident 6; - 87 tablets of hydrocodone-acetaminophen 10 mg/325 mg for Resident 7; - 60 tablets of tramadol 50 mg for Resident 8; - 24 tablets of tramadol 50 mg for Resident 9; - 48 tablets of tramadol 50 mg for Resident 10; and - 84 tablets of tramadol 50 mg for Resident 11. <p>The DON stated with each of the above missing controlled medications, the perpetrator drew a line across the controlled medication log, wrote the medication had been transferred to the DON, [NAME] the DON's signature, and [NAME] the signature of the witnessing nurse. The DON stated a narcotic count was done at the change of each shift, but the drug diversion went unnoticed because when the controlled substance log was crossed off, it showed the controlled medications were now in the possession of the DON. The DON stated the person or persons diverting the controlled medications chose the residents who had large amounts of controlled medications on hand, residents who took pain medication infrequently, or residents who were transferred out.</p> <p>On [DATE] at 1040 hours, a follow-up interview and concurrent facility document review was conducted with the DON. The DON stated during the facility's investigation, the facility discovered 84 tablets of tramadol 50 mg were missing for Resident 11.</p>