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	02/14/2025

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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49348 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the appropriate dietary texture was provided for one of four sampled residents (Resident 1) as ordered by the physician. * The facility failed to ensure Resident 1 was provided with the appropriate food texture as per the physician's diet orders. This failure had put Resident 1 at risk for choking. Findings: Review of the facility's document titled Regular Pureed Diet dated 2020 showed the pureed diet is a regular diet that has been designed for the residents who have difficulty chewing and/or swallowing. The texture should be of a smooth and moist consistency and able to hold its shape. Foods such as cakes, cookies, pancakes, and breads may be soaked in milk syrup or slurries until the proper consistency is achieved. Additionally, the document showed the breads may be soaked in liquids such as milk, soup, broth or gelatin water or pureed; and under the miscellaneous section to avoid showed no peanut butter. Review of the facility's document titled Snack Spreadsheet (undated) showed if there is an x in the box, this item is not allowed. Further review of the Snack Spreadsheet showed the peanut butter sandwich and PB (peanut butter) and jelly sandwiches were marked with an x for the residents on pureed diet. Closed medical record review for Resident 1 was initiated on [DATE]. Resident 1 was admitted to the facility on [DATE], and had expired in the facility on [DATE]. Resident 1's diagnoses included dysphagia, acute respiratory failure, epilepsy, and autism. Review of Resident 1's H&P examination dated [DATE], showed Resident 1 had a fluctuating capacity to understand and make medical decisions. Review of Resident 1's BIMS dated [DATE], showed a score of 01 indicating severe cognitive impairment. Review of Resident 1's Progress Note and Change in Condition Evaluation dated [DATE], showed the resident had a choking episode with subsequent seizure like activity. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's ST Progress Notes dated [DATE], showed Resident 1's diet was downgraded to puree consistency to reduce the risk for aspiration. Review of Resident 1's Order Summary Report showed a physician's order dated [DATE], for Resident 1's diet as fortified, puree texture, and nectar thick consistency. Review of Resident 1's Progress Notes dated [DATE], showed at approximately 0140 hours, the CNA approached the nurses' station stating Resident 1 was not breathing. The note showed when the nurse entered the room, Resident 1 was slouched forward unresponsive; and the nurse was unable to palpate the resident's pulse. Food was seen in Resident 1's mouth, Heimlich maneuver was performed, and a small amount of food was expelled from Resident 1's mouth. The CPR was initiated, the code blue was called, and the 911 was called by another licensed nurse. Review of Resident 1's Physicians Progress Notes dated [DATE], showed the physician was made aware Resident 1 had expired suddenly. The note further showed Resident 1 had been having breakthrough seizures during his stay, and it was a possibility a seizure event might have contributed to his asphyxiation. The note also showed the resident had behavior problems, difficulty to redirect, crawling on the floor, and biting at staff. The sandwiches were the primary food he would request and often used to settle the resident's behaviors On [DATE] at 1117 hours, an interview was conducted with HA 1. HA 1 stated during her shift (on [DATE]), Resident 1 was upset stating he was hungry as he pointed to the bedside table where there was food. HA 1 stated she gave Resident 1 two sandwiches that were at the bedside table. The resident was still hungry after having finished the two sandwiches. She gave Resident 1 the third sandwich and he was about to finish the sandwich, he chewed and swallowed, mimicked the chewing again, opened his mouth, and froze with his eyes fixed, so she went to get help. When asked what kind of sandwiches they were, HA 1 stated a peanut butter sandwich, and one sandwich had strawberry jelly. When asked if the sandwiches were a regular sandwich texture or blended, HA 1 stated it was a regular sandwich texture. When asked if Resident 1's diet was ever communicated with her, HA 1 stated no. On [DATE] at 0911 hours, an interview was conducted with the Administrator and DON. The Administrator stated the food given to the resident was inconsistent with the resident's diet. The Administrator stated there was an order for pureed diet and they should have given Resident 1 pureed food. On [DATE] at 1412 hours, a follow-up interview was conducted with HA 1. HA 1 stated the resident had been always eating those sandwiches, so she always provided the sandwiches. On [DATE] at 0912 hours, an interview and concurrent closed medical record review was conducted with RN 1. RN 1 stated the process for communicating with the HA was that if the HA needed something, the HA was responsible to communicate with the CNA or licensed nurses. RN 1 verified Resident 1's diet orders were fortified, pureed texture, nectar thick liquids. When asked if a sandwich was allowed for a pureed diet, RN 1 stated no, it had to be pureed, blended. On [DATE] at 1452 hours, the Administrator and DON were made aware and acknowledged the above the findings.