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	05/06/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 7) and two nonsampled residents (Residents 31 and 175) reviewed for respiratory care were provided the appropriate respiratory care. * The facility failed to ensure Resident 7 nasal canula tubing was dated and labeled and had an oxygen storage bag as per the facility's P&P. * The facility failed to ensure Resident 31's nasal cannula tubing was dated and labeled as per the facility's P&P. * The facility failed to ensure Resident 175 nasal canula tubing was dated and labeled and had an oxygen storage bag as per the facility's P&P. These failures had the potential for the residents to not receive the appropriate care and may negatively impact the residents' medical conditions.Findings: Review of the facility's P&P titled Use of Oxygen revised 5/2021 showed it is the policy of this facility to promote resident safety in administering oxygen. The oxygen cannula or masks, tubings will be changed at least every 7 (seven) days. The tubing should be kept off the floor. Labeled and dated bags should be provided for cannulas and masks to be placed in when not in use. 1. On 5/3/26 at 1235 hours, a dining room observation and concurrent interview for Resident 31 were conducted with LVN 2. LVN 2 verified that Resident 31 was on oxygen at two liters per minute and that the nasal cannula tubing was unlabeled and undated. LVN 2 further stated that oxygen tubing needs to be changed every seven days to prevent infection. Medical record review for Resident 31 was initiated on 5/3/26. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 1/21/26, showed Resident 31 had no capacity to make medical decisions. Review of Resident 31's Order Summary Report dated 5/4/26, showed a physician's order dated 4/9/26, to administer oxygen at two liters per minute via nasal continuously. On 5/6/26 at 1024 hours, an interview for Resident 31 was conducted with the DON. The DON verified the above findings. The DON stated the nasal cannula should have been labeled with the date when the tubing was change, for infection control. On 5/6/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 5/3/26 at 1235 hours, a dining observation and concurrent interview were conducted with LVN 2 in the dining room for Resident 7. Resident 7 was observed on portable oxygen at two liters per (continued on next page)

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

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	05/06/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minute, and the nasal cannula tubing was noted to be undated, unlabeled, and without a storage bag. LVN 2 verified that Resident 7's nasal cannula tubing was not labeled or dated and that there was no oxygen storage bag present. LVN 2 stated the nasal cannula should be labeled with the date and changed every seven days. Medical record review for Resident 7 was initiated on 5/4/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 3/4/26, showed Resident 7 had no capacity to make medical decisions due to dementia. Review of Resident 7's Order Summary Report dated 5/4/26, showed a physician's order dated 3/12/26, to administer oxygen at two liters per minute via nasal continuously every shift. 3. On 5/3/26 at 1230 hours, a dining observation and concurrent interview for Resident 175 were conducted with LVN 2 in the dining room. Resident 175 was observed on portable oxygen at two liters per minute, and the nasal cannula tubing was noted to be undated, unlabeled, and without a storage bag. LVN 2 verified that Resident 175's nasal cannula tubing was not labeled or dated and confirmed that there was no oxygen storage bag. LVN 2 stated the nasal cannula should be labeled with the date and changed every seven days. Medical record review for Resident 175 was initiated on 5/4/26. Resident 175 was admitted to the facility on [DATE]. Review of Resident 175's H&P examination dated 2/23/26, showed Resident 175 had the capacity to make medical decisions. Review of Resident 175's Order Summary Report dated 5/5/26, showed a physician's order dated 3/8/26, to administer oxygen at two liters per minute via nasal continuously every shift for shortness of breath. On 5/6/26 at 1430 hours, an interview was conducted with the Administrator and DON for Residents 7 and 175. The Administrator and DON were informed and acknowledged the above findings.

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	05/06/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the dialysis care and services were provided for three of three final sampled residents (Residents 2, 12, and 81) reviewed for dialysis care. * The facility failed to ensure the Dialysis Communication Forms for Resident 2 were completed and accurate on multiple dates. * The facility failed to ensure Resident 12's hemodialysis communication records were complete and failed to ensure accurate documentation of the monitoring of Resident 12's fluid restriction as ordered by the physician. * The facility failed to ensure Resident 81's hemodialysis communication records and fluid intake monitoring were completed accurately. These failures had the potential of not identifying negative outcomes for Residents 2, 12, and 81. Findings: Review of the facility's P&P titled Dialysis (Renal), Pre- and Post-Care reviewed 4/2025, showed it is the policy of this facility to: - assist the resident in maintaining hemostasis pre-and post-renal dialysis; - assess and maintain patency of renal dialysis access; - participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. Further review of the P&P showed the dialysis access should be assessed upon the resident's return to the facility for patency, any unusual redness, swelling and bleeding. Documentation related to pre- and post-dialysis care will be placed in the clinical record and include: a. Resident assessments, interventions, and any provided education. b. Assessment of renal dialysis access site to include absence and quality of a bruit and thrill for residents with an arteriovenous fistula c. Communication between facility and dialysis staff or medical provider. 1. On 5/3/26 at 0910 hours, an interview was conducted with Resident 2. Resident 2 stated he received hemodialysis treatment three times a week and on fluid restriction but the resident would not specify the dialysis dates or the amount of the fluid restriction. Resident 2 showed he has a Permacath on the right upper chest. Medical Record review for Resident 2 was initiated on 5/4/26. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's Order Summary Report dated 5/4/26, showed the following physician's orders: - dated 1/3/26, to assess the shunt/dialysis site every shift and document: C=Clear, T=Tenderness, R=Redness, B=Bleeding every shift for right upper chest Permacath site. - dated 4/16/26, for Resident 2 to receive the hemodialysis treatments every Tuesday, Thursday and (continued on next page)

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	05/06/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Saturday with Dialysis Center B. Review of Resident 2's Dialysis Center Nursing Communication Records showed inaccurate documentation on the following dates: - dated 2/5/26, Facility Nurse/Post Dialysis section showed bruit and thrill were present. - dated 3/12/26, Facility Nurse/Post Dialysis section showed bruit and thrill were present and failed to show documentation of the assessment of Resident 2's hemodialysis site for sign and symptoms of infection. - dated 4/11/26, Facility Nurse/Pre-Dialysis and Post-Dialysis sections showed bruit and thrill were present. - dated 4/14/26, Facility Nurse/Post Dialysis section showed bruit and thrill were present. - dated 4/16/26, Facility Nurse/Pre-Dialysis section showed bruit and thrill were present. - dated 4/21/26, Facility Nurse/Post Dialysis section showed bruit and thrill were present. - dated 4/28/26, Facility Nurse/Post-Dialysis sections showed bruit and thrill were present. - date 4/30/26, Facility Nurse/Post-Dialysis section showed bruit and thrill were present. - dated 5/2/26, Facility Nurse/Post -Dialysis sections failed to show documentation of the assessment of Resident 2's hemodialysis access site for sign and symptoms of infection, bleeding, dressing in place, vital signs including the blood pressure, pulse rate, respiration rate, temperature, shortness of breath and the present of pain. On 5/4/26 at 1106 hours, an interview and concurrent medical record review for Resident 2 were conducted with the MDS Assistant. The MDS Assistant verified the above findings and stated Resident 2's dialysis access site was a right upper chest (RUC) Permacath. The MDS Assistant stated a bruit and thrill would not be assessed for residents with a Permacath. The MDS Assistant further stated that the documentation should be accurate. On 5/6/26 at 1437 hours, an interview with the DON and Administrator was conducted. The DON and Administrator informed and acknowledge the above findings. 2. On 5/3/26 at 0923 hours, an interview was conducted with Resident 12. Resident 12 stated he was on fluid restrictions and received hemodialysis treatments every Tuesday, Thursday, and Saturday. Resident 12 was able to show his hemodialysis access located in his left arm. Medical record review for Resident 12 was initiated on 5/3/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's H&P examination dated 4/26/26, showed Resident 12 had the capacity to make medical decisions. (continued on next page)

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	05/06/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Review of Resident 12's Order Summary Report dated 5/5/26, showed the following physician's orders: - dated 4/26/26, to assess Resident 12's left Arteriovenous (AV) fistula shunt (a surgically created connection between and artery and vein for hemodialysis treatments) site for bruit (a turbulent whooshing sound heard with a stethoscope over a blood vessel) and thrill (the palpable vibration felt with your fingers in the same location), every shift; and to document + (positive) or – (negative) for the presence of bruit and thrill. To call the physician for absences. - dated 4/26/26, to assess Resident 12's shunt/dialysis site every shift and document the following: C=clear, T= tenderness, R=redness, B=bleeding, every shift. - dated 4/29/26, for Resident 12 to receive the hemodialysis treatments every Tuesday, Thursday, and Saturday with Dialysis Center A. Review of Resident 12's Dialysis Center Nursing Communication Records showed the following missing documentation: - the pre- dialysis treatment section dated 1/17/26, failed to show the documentation of Resident 12's respirations. The post- dialysis treatment section failed to show the documentation of Resident 12's vital signs including the blood pressure, pulse rate, respiration rate, temperature and the presence of pain. - the post- dialysis treatment section dated 1/22/26, failed to show the documentation of the assessment of Resident 12's hemodialysis access site for bleeding and for the presence of bruit and thrill. - the post- dialysis treatment section dated 2/7/26, failed to show the documentation of the assessment of Resident 12's hemodialysis access site for bleeding and for the presence of bruit and thrill. - the dialysis treatment section dated 2/24/26, failed to show the documentation of the assessment of Resident 12's lung sounds. The post- dialysis treatment section failed to show the documentation of the assessment of Resident 12's hemodialysis access site for the presence of bruit and thrill. - the pre- dialysis treatment section dated 4/16/26, failed to show the documentation of the assessment of Resident 12's hemodialysis access site for the presence of bruit and thrill, for any bleeding, and for any signs of infection. The post-dialysis treatment section failed to show the documentation of the assessment of Resident 12's hemodialysis access site for the presence of bruit and thrill, for any bleeding, for any signs of infection at the hemodialysis site, and for the presence of any shortness of breath. - the pre- dialysis treatment section dated 4/23/26, failed to show the documentation of the assessment of Resident 12's hemodialysis access site for the presence of bruit and thrill, for any bleeding, and for any signs of infection. b. Review of Resident 12's Order Summary Report dated 5/5/26, showed the following physician's orders: (continued on next page)

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	05/06/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 4/26/26, to assess Resident 12's left Arteriovenous (AV) fistula shunt (a surgically created connection between and artery and vein for hemodialysis treatments) site for bruit (a turbulent whooshing sound heard with a stethoscope over a blood vessel) and thrill (the palpable vibration felt with your fingers in the same location), every shift; and to document + (positive) or – (negative) for the presence of bruit and thrill. To call the physician for absences. Review of Resident 12's MAR for April and May 2026 showed the licensed nurse documented - on 4/15/26 during the 1500 to 2300 hours shift and on 4/17/26 during the 2300 to 0700 hours shift. Review of Resident 12's medical record failed to show the physician was notified of the absence of bruit/thrill for Resident 12's hemodialysis site access on 4/15 and 4/17/26. c. Review of Resident 12's Order Summary Report dated 5/5/26, showed the following physician's orders: - dated 4/26/26, every evening shift, to calculate Resident 12's total 24-hours fluid restriction. - dated 4/29/26, for Resident 12 to have a total fluid restriction of 1500 ml per day from dietary and nursing. The total nursing fluids of 420 ml per day: for the 0700 to 1500 hours shift = 160 ml, 1500 to 2300 hours shift = 160 ml, and 2300 to 0700 hours shift = 100 ml, every shift. - dated 4/29/26, total fluid restriction of 1500 ml per day. 1080 ml dietary fluid per day. Breakfast = 260 ml, Lunch = 360 ml, and dinner = 360 ml, after meals. Review of Resident 12's MARs for April and May 2026 showed the following documentation for fluid restrictions of 1500 ml per day as follows: nursing to provide 420 ml per day and dietary to provide 1080 ml per day total. - on 4/4/26, the licensed nurses documented Resident 12 received 770 ml for the dietary fluids and 370 ml for the nursing fluids (a total of 1140 ml). However, the licensed nurse documented Resident 12 received 1500 ml in the 24-hour period. - on 4/5/26, the licensed nurses documented Resident 12 received 720 ml for the dietary fluids and 420 ml for the nursing fluids (a total of 1140 ml). However, the licensed nurse documented Resident 12 received 1500 ml in the 24-hour period. - on 4/6/26, the licensed nurses documented Resident 12 received 770 ml for the dietary fluids and 370 ml for the nursing fluids (a total of 1140 ml). However, the licensed nurse documented Resident 12 received 1500 ml in the 24-hour period. - on 4/7/26, the licensed nurses documented Resident 12 received 770 ml for the dietary fluids and 370 ml for the nursing fluids (a total of 1140 ml). However, the licensed nurse documented Resident 12 received 1,500 ml in the 24-hour period. - on 4/13/26, the licensed nurses documented Resident 12 received 720 ml for the dietary fluids and 420 ml for the nursing fluids (a total of 1,140 ml). However, the licensed nurse documented Resident 12 received 1500 ml in the 24-hour period. - on 4/18 and 4/23/26, the licensed nurse documented Resident 12 received 720 ml for the dietary (continued on next page)

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	05/06/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluids and 420 ml for the nursing fluids (a total of 1140 ml). However, the licensed nurse documented Resident 12 received 1500 ml in the 24-hour period. - on 5/2/26, the licensed nurse documented Resident 12 received 720 ml for the dietary fluids and 420 ml for the nursing fluids (a total of 1140 ml). However, the licensed nurse documented Resident 12 received 1500 ml in the 24-hour period. - on 5/4/26, the licensed nurse documented Resident 12 received 1080 ml for the dietary fluids and 370 ml for the nursing fluids (a total of 1450 ml). However, the licensed nurse documented Resident 12 received 1500 ml in the 24-hour period. On 5/5/26 at 1030 hours, an interview and concurrent medical record review for Resident 12 was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated the documented 24-hour fluid intake calculated during the 1500 to 2300 hours shift was not done accurately. Additionally, LVN 6 stated the hemodialysis communication record should be complete. On 5/6/26 at 1049 hours, an interview was conducted with the DON. The DON stated the Dialysis Center Nursing Communication Records was used as a form of communication between the dialysis center and the facility. The DON stated the licensed nurses were responsible for completing the pre- and post- dialysis treatment sections and the dialysis nurse should complete the dialysis section. The DON further stated all the areas on the dialysis communication record should be completed. The DON stated for the residents with a physician's order for fluid restrictions, the licensed nurses were in responsible for the tracking of the fluid intake and documented the total in the MAR. The DON stated the monitoring and tracking should be accurate to account for fluids the resident actually received. On 5/6/26 at 1444 hours, an interview was conducted with the Administrator, DON, and Clinical Resource Nurse. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 3. Medical record review for Resident 81 was initiated on 5/3/26. Resident 81 was admitted to the facility on [DATE], and readmitted back to the facility on 4/28/26. Review of Resident 81's H&P examination dated 4/30/26, showed Resident 81 had the capacity to make medical decisions. Review of Resident 81's Dialysis Center Nursing Communication Record showed inaccurate documentation on the following dates: - dated 4/18/26, Facility Nurse/Pre-Dialysis section showed bruit and thrill were present. - dated 4/16/26, Facility Nurse/Pre-Dialysis section showed bruit thrill were present. - dated 4/9/26, Facility Nurse/Pre-Dialysis and Post-Dialysis sections showed bruit and thrill were present. Review of Resident 81's Order Summary Report for May 2026 showed the following physician's orders: - dated 4/28/26, for total fluid restriction per day 1000 ml. From dietary and nursing, total nursing (continued on next page)

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	05/06/2026

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluids per day 280 ml; 7-3 PM shift 100 ml, 3-11 PM shift 100 ml, and 11-7 PM shift 80 ml. - dated 4/28/26, for total fluid restriction per day 1000 ml. Total dietary fluid per day is 720 ml, breakfast 240 ml, lunch 240 ml, and dinner 240 ml. - dated 4/28/26, for hemodialysis site to right upper chest (RUC) Permacath. - dated 1/20/25, for hemodialysis days on Tuesday, Thursday, and Saturday schedule time at 0915 hours. - dated 4/29/26, for post dialysis RUC catheter check for bleeding every Tuesday, Thursday, and Saturday Review of Resident 81's Nursing Progress Notes dated 5/5/26 at 2037 hours, showed facility staff spoke with ER Nurse at Hospital A and was informed Resident 81 was admitted to the acute care hospital. Review of Resident 81's MAR for May 2026 showed Resident 81 received 240 ml fluids from the dietary on 5/5/26 at 1800 hours. On 5/6/26 at 0901 hours, an interview and concurrent medical record review for Resident 81 were conducted with LVN 1. LVN 1 verified the above findings and stated Resident 81's dialysis access was a right upper chest (RUC) Permacath. LVN 1 stated a bruit and thrill would not be assessed for the residents with a Permacath. LVN 1 further stated the documentation should be accurate. LVN 1 also verified that Resident 81 was transferred to an acute care hospital from the dialysis center on 5/5/26, and had not returned to the facility. LVN 1 further confirmed the MAR dated 5/5/26 at 1800 hours, showed the resident received 240 mL of fluids from the dietary. LVN 1 stated the resident did not return to the facility on 5/5/26 at 1800 hours, and the documentation was inaccurate. On 5/6/26 at 1430 hours, an interview with the Administrator, DON, Clinical Resource Nurse, and Dietary Resource was conducted. The Administrator, DON, Clinical Resource Nurse, and Dietary Resource acknowledged findings.

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	05/06/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to store the drugs and biologicals in a safe manner for two of three medication carts (Medication Carts A and B); and two of 32 final sampled residents (Residents 132 and 164). * The facility failed to ensure safe medication labeling practices was in accordance with the accepted professional standards when the opened inhaler mouthpieces and nasal spray bottles were not properly labeled with sufficient information to clearly identify the specific resident for Resident 192 in Medication Cart A, and Residents 67, 117, and 158 in Medication Cart B. These failures had to potential to cause medication errors and preventable infections from cross-contamination from other residents if accidently mixed up with other residents' similar or same drugs. * The facility failed to ensure the two medication cups of ammonium lactate cream (used to hydrate, soften, and exfoliate dry, rough, and scaly skin conditions) were not left on Resident 164's bedside table unattended. This failure posed the risk for unauthorized individuals to have access to the medications. * The facility failed to ensure the Neosporin (antibiotic) ointment was not left in Resident 132's overbed table at bedside. This failure posed the risk for unauthorized individuals to have access to the medications.Findings: 1. Review of the facility's P&P titled Medication Storage and Labeling reviewed on 4/10/26, showed it is the policy of this facility is all drugs will be labeled and stored in a manner consistent. federal and state regulations, and to enhance accurate and safe medication administration by the facility staff. a. On 5/4/25 at 1532 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 6. When Medication Cart A was inspected, Resident 192 had one opened carton of azelastine nasal solution (over-the-counter antihistamine spray used to treat allergy symptoms like sneezing, itchy or runny nose, and nasal congestion) and one opened carton of ipratropium nasal solution (an anticholinergic medication used to treat a runny nose). Both the azelastine and ipratropium nasal spray bottles were observed unlabeled without resident-specific information. LVN 6 verified the two unlabeled nasal spray bottles was for Resident 192. LVN 6 stated the medication containers were to be labeled in case it falls out of the opened medication cartons. b. On 5/4/25 at 1543 hours, an observation of Medication Cart B and concurrent interview was conducted with RN 2. When Medication Cart B was inspected and showed the following: - Resident 158 had one opened carton of budesonide-formoterol (breathing treatment) inhaler; - Resident 117 had one opened carton of Tudorza Pressair (breathing treatment) inhaler; and - Resident 67 had one opened carton of azelastine (anti-allergy medication) nasal solution. Further review of Medication Cart B showed Resident 158's budesonide-formoterol inhaler mouthpiece, Resident 117's Tudorza Pressair inhaler mouthpiece, and Resident 67's azelastine nasal solution bottle were observed unlabeled without resident-specific information. RN 2 verified the above unlabeled inhaler mouthpieces and the unlabeled nasal spray bottles. RN 2 stated the inhaler mouthpieces and nasal spray bottle were to be labeled with the resident's information to make sure it was administered to the right resident. (continued on next page)

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	05/06/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/26 at 1345 hours, an interview was conducted with the DON. The DON acknowledged the concern of medications getting mixed up. The DON stated this could result medication errors. The DON stated for the infection control outcome, obviously, spread disease among the residents. 2. Review of the facility's P&P titled Medication Storage and Labeling(undated) showed the following: - storage of non-legend (over the counter drugs) drugs at bedside shall meet the following conditions: the manner of storage shall prevent access by other residents, the facility shall record in the resident health record the bedside medications used by the resident and the quantity of each drug supplied to the resident for bedside storage shall be recorded in the health record each time the drug is supplied; and - residents who own over the counter medications are kept in original containers and labeled with the resident's name and room number. On 5/4/26 at 0809 hours, an observation was conducted for Resident 164. Resident 164 was observed lying in bed. Two medication cups of white cream was observed inside the open bedside table drawer. On 5/4/25 at 0829 hours, a follow-up observation, interview and concurrent medical record review for Resident 164 was conducted with LVN 3. LVN 3 verified the two medication cups of white cream was ammonium lactate cream and it was used for Resident 164's xerosis. Medical record review for Resident 164 was initiated on 5/3/26. Resident 164 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 164's MDS annual assessment dated [DATE], showed Resident 164's Cognitive Skills for Daily Decision Making was severely impaired. Review of Resident 164's Order Summary Report showed the following physician's order dated 4/29/26, to apply 12% of ammonium lactate cream to general body every day shift for xerosis (abnormally dry, rough and scaly skin caused by lack of moisture in the skin's top layer). Further review of Resident 164's Order Summary Report failed to show a physician's order to self-administer ammonium lactate cream, nor to keep the ammonium lactate cream at the bedside. On 5/4/26 at 0854 hours, an interview and medical record review for Resident 164 was conducted with LVN 2. LVN 2 verified there was no physician's order to self-administer the ammonium lactate cream, nor to keep the ammonium lactate cream at the resident's bedside. LVN 2 stated no medication should be at the resident's bedside table. LVN 2 further stated it would pose a risk for other residents or visitor to take the medication. On 5/6/26 at 1024 hours, an interview was conducted with the DON. The DON stated no medication should be at the resident's bedside due to the risk for other residents to take the medication and self-administer. The DON acknowledged the above findings. On 5/6/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed about the medication found at bedside and acknowledged the findings. (continued on next page)

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	05/06/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of the facility's P&P titled Medication Storage and Labeling (undated) showed the following: - storage of non-legend (over the counter drugs) drugs at bedside shall meet the following conditions: the manner of storage shall prevent access by other residents, the facility shall record in the resident health record the bedside medications used by the resident and the quantity of each drug supplied to the resident for bedside storage shall be recorded in the health record each time the drug is supplied; and - residents who own over the counter medications are kept in original containers and labeled with the resident's name and room number. On 5/3/26 at 830 hours, during the initial tour of the facility, Resident 132 was observed with Neosporin ointment on top of the overbed table. Resident 132 stated the nurse gave the medication for Resident 132 to keep. Medical record review for Resident 132 was initiated on 5/4/26. Resident 132 was admitted to the facility on [DATE]. Review of Resident 132's H&P dated 4/12/26, showed Resident 132 had the capacity to understand and make decisions. Review of Resident 132s Order Summary Report dated 5/6/26, failed to show a physician's order for Neosporin ointment use. Further review of Resident 132's medical record failed to show the self- administration assessment or care plan for the use of Neosporin ointment. On 5/3/26 at 1050 hours, an observation for Resident 132 and concurrent interview was conducted with CNA 6. Resident 132 was observed with the Neosporin ointment on her hand and Resident 132 stated she did not want the medication to be touched. CNA 6 verified the presence of Neosporin ointment at Resident 132's bedside. CNA 6 stated, I did not realize she had that. On 5/3/26 at 1052 hours, an observation and concurrent interview was conducted with RN 2. RN 2 verified the presence of Neosporin ointment at Resident 132's bedside. RN 2 stated no resident should have any medication at the bedside unless they were assessed for self-administration and care planned. On 5/6/26 at 1615 hours, an interview with the Administrator and DON was conducted. The Administrator and the DON were informed regarding Resident 132's Neosporin ointment at bedside. The Administrator and DON acknowledged the findings.

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	05/06/2026

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu and recipes were followed for 26 of 153 residents (Resident 94, 18 of 18 residents who received pureed food and seven of seven residents on a renal diet) eating from the kitchen. * The facility failed to ensure the puree recipe for IDDSI Level 4 Pureed Starch (Rice, Pasta, Polenta, Potatoes, etc.) was followed. * The facility failed to follow the renal diet menu. * The facility failed to inform the residents of menu changes. * The facility failed to offer Resident 94 appropriate food substitutions when he refused both breakfast and lunch. These failures had the potential to result in residents on special diets not receiving adequate nutritional and caloric intake as recommended.Findings: Review of the facility's Diet Type Report dated 5/3/26 and revised on 5/4/26, showed 153 residents consumed food prepared in the kitchen, with seven residents on renal diets and 18 residents on pureed diets. 1. Review of the facility's P&P titled IDDSI Level #4: Regular Pureed Diet dated 2025 showed the pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the prepared pureed food items included on this diet should be smooth and free of lumps, hold their shape, while not being too firm or sticky, and should not weep. The P&P further showed all foods are to be prepared in a food processor or blender. Additional liquids, such as broth, gravy, vegetable or fruit juices, or milk, and potentially food thickeners are added to achieve the appropriate final consistency. Review the facility document titled Recipe: Pureed (IDDSI Level #4) Starch (Rice, Pasta, Polenta, Potatoes, etc) dated 2025 showed the directions were to puree the potatoes on low speed to a paste consistency before adding any liquid. Further directions for pureed potatoes showed to gradually add warm milk. On 5/4/26 at 1053 hours, during a puree observation for pureed potatoes, [NAME] 1 was observed adding 25 servings of potatoes in the blender and then added two cups of warm milk into the blender before blending. On 5/4/26 at 1115 hours, an interview and concurrent facility document review was conducted with [NAME] 1. [NAME] 1 verified the above findings and stated the recipe for pureed potatoes was not followed. 2. Review of the facility's P&P titled Menu Planning dated 2023 showed menus and cook's spreadsheets are to be dated and posted in the kitchen and on the consumer bulletin board in the entrance of the facility by the FNS Director two weeks in advance. All daily menu changes, with the reason for the change, are to be noted on the back of the kitchen spreadsheet or a logbook may be kept. The facility Registered Dietitian is to sign and date spreadsheets when changes are made. Menu changes should also be noted on menus on the consumers board and any other menus which may be posted. Review of the facility's P&P titled Renal 80-Gram Protein, Low Salt, Low Potassium, In Combination with Controlled Carbohydrate (CCHO) (undated) showed this diet is used for the diabetic resident with (continued on next page)

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	05/06/2026

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	renal insufficiency at the 80 grams level of protein, low salt, and low potassium. The diet may be inadequate in certain vitamins and minerals. Review of the facility document titled Spring Menus dated 5/4/26, showed the residents on the renal diets are to receive brown rice with margarine, wheat roll, and pineapple and mandarin orange mix. On 5/4/26 at 1310 hours, during tray line observation and concurrent interview was conducted with RD 1 and the DSS. Reviews of Resident 94 and 175's meal ticket showed both residents were on renal diets. However, during the tray line observation, Residents 94 and 175 did not receive brown rice with margarine, the wheat roll, and pineapple and mandarin orange mix per the facility's menu. RD 1 stated the brown rice was available but was not cooked in time for lunch and macaroni pasta was substituted without informing the residents. The DSS stated the facility did not prepare the fruit mold as per the Spring Menu for renal diets. The DSS stated the fruit mold had bananas while the pineapple and mandarin orange mix did not. RD 1 and the DSS verified the residents were not informed of the change in the menu and none of the residents on renal diet received brown rice with margarine and the pineapple and mandarin orange mix. RD 1 stated the facility should follow the therapeutic diet. 3. Review of the facility's P&P titled Purchasing and Food and Supplies dated 2023 showed food supplies are ordered each week from an appropriate vender. The FNS Director, who selects all suppliers, is responsible for specifying the quantity of food desired. Proper procedures are to be followed in purchasing food and seeing that food is delivered. Frequency of purchasing and delivery is determined by storage space, product type, and frequency of use. Review of the facility document titled Spring Menus dated 5/3/26, showed the residents on renal diets are to receive roast beef SF (salt free) gravy for lunch. Review of the facility document titled Sysco Customer's Invoice dated 4/16/26, showed the facility received six cases of beef roast on 4/16/26. Review of the facility document titled Sysco Customer's Invoice dated 4/22/26, showed the facility received three cases of roast beef on 4/22/26. On 5/3/26 at 1213 hours, during the dining observation, Resident 175's meal ticket for lunch showed the resident was on a renal diet. Resident 175 received a beef patty instead of roast beef with SF gravy. On 5/3/26 at 1248 hours, an observation and concurrent interview was conducted with the DSS in the dining room. The DSS verified Resident 175 and residents with renal diets did not receive roast beef with SF gravy as per the menu. The DSS stated the facility was out of stock for the roast beef and beef patty was substituted. On 5/3/26 at 1315 hours, an interview was conducted with Resident 12. Resident 12 stated he was not informed of the menu change from roast beef to beef patty. When asked if he ate the beef patty, Resident 12 stated he did not and was looking forward to the roast beef. On 5/4/26 at 0830 hours, an interview was conducted with the RD 1 and the DSS. RD 1 verified the Sysco Customer's Invoices for the roast beef and stated the facility had roast beef on hand. When asked why the residents were not served roast beef for lunch on 5/3/26, as per the menu, the DSS stated the facility did not thaw the roast beef in time for lunch. The DSS further stated the recipe (continued on next page)

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	05/06/2026

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should match what was posted on the menu. On 5/6/26 at 1430 hours, an interview was conducted with the Administrator, DON, Clinical Resource Nurse, and Dietary Resource. The Administrator, DON, Clinical Resource Nurse, and Dietary Resource were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Food Substitutions For Residents Who Refuse The Meal reviewed dated 4/10/26, showed nursing personnel will ask any resident who does not eat his meal or food item as to why he is not eating and offer substitution in accordance with the resident's diet order. Medical record review for Resident 94 was initiated on 5/3/26. Resident 94 was admitted to the facility on [DATE]. Review of Resident 94's H&P examination dated 12/26/25, showed Resident 94 had no capacity to make medical decisions. Review of Resident 94's Documentation Survey Report v2 dated 5/3/26, under section Amount Eaten, showed Resident 94 refused breakfast and lunch. On 5/3/26 at 1324 hours, an observation and concurrent interview was conducted with Resident 94. Resident 94's lunch tray was observed far from him on his overbed table. Resident 94 stated he did not like the food and was not offered anything else. On 5/3/26 at 1352 hours, an interview was conducted with CNA 1. CNA 1 verified delivering Resident 94's lunch tray. CNA 1 stated Resident 94 refused to eat his lunch but asked her to keep the tray at bedside. CNA 1 further stated food substitutions were not offered to Resident 94. On 5/5/26 at 0846 hours, an interview and concurrent medical record review was conducted with the DSD. The DSD stated when residents refuse to eat their meals, the CNAs were expected to offer the meals three times and offer food substitutions, using paper communication to request items from the kitchen. The DSD could not provide paper documentation or electronic records showing substitutions were offered for breakfast or lunch on 5/3/26, for Resident 94. On 5/6/26 at 1458 hours, an interview was conducted with the DON, Clinical Resource and Administrator. The DON, Clinical Resource, and Administrator were informed and acknowledged the findings above.

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	05/06/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure food safety and sanitary requirements were met in the kitchen. * The facility failed to ensure food preparation equipment was in good, cleanable and sanitary condition. * The facility failed to ensure temperature was monitored in the dry storage room. * The facility failed to ensure food items were labeled and discarded by the best by or use by date. These failures had the potential to cause foodborne illnesses in the medically vulnerable residents population who consumed food prepared in the kitchen.Findings: Review of the facility's document titled Diet Type Report revised on 5/4/26, showed 153 residents received food from the kitchen. 1. Review of the facility's P&P titled Sanitation dated 2023 showed correct temperatures for the storage and handling of foods are used. Thermometers will be used to check temperatures of refrigerators, freezers, and food storerooms. Review of the facility's P&P titled Storage of Food and Supplies dated 2023 showed the food and supplies will be stored properly and in a safe manner. The storeroom should be well-lighted, well-ventilated, cool, dry, and clean at all times. Thermometers should be placed in all storage areas and changed frequently. Recommended temperature is 50 to 85 degrees Fahrenheit if dry food storage goes over 85 degrees Fahrenheit take corrective action. On 5/3/26 at 0840 hours, an observation and concurrent interview was conducted with DSS in the kitchen's dry storage room. The DSS verified the facility had no temperature monitoring log or system for the dry storage area. The DSS stated the temperature should be checked to ensure food kept in the storage room was stored at appropriate temperature levels. 2. According to the USDA Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils: (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch.(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 5/3/26 at 0818 hours, an observation and concurrent interview was conducted with the DSS. The following was observed:- One can opener with brown discoloration, silver shavings, and dirt particles.- One mixer with dried food particles.The DSS verified the above findings and stated kitchen equipment should be cleaned and sanitized to prevent contamination of foods prepared in the kitchen. 3. Review of the facility's P&P titled Storage of Food and Supplies dated 2023 showed food and supplies will be stored properly and in a safe manner. On 5/3/26 at 0808 hours, an observation and concurrent interview was conducted with the DSS inside Walk-In Refrigerator 1. One container of ham showed a use by date of 4/28/26. The ham packaging had no label or date. The DSS verified the findings and stated food items should be labeled to ensure kitchen staff are aware of when food should be served. On 5/6/26 at 1430 hours, an interview was conducted with the Administrator, DON, Clinical Resource Nurse, and Dietary Resource. The Administrator, DON, Clinical Resource Nurse, and Dietary Resource were informed and acknowledged the above findings.

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	05/06/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to implement its Infection Prevention and Control Program in accordance with the facility's P&P. * The facility failed to implement its infection control surveillance program for April 2025 through February 2026. The facility conducted surveillance only for the residents prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and/or symptoms of infection but not prescribed antimicrobial medications met McGeer's criteria for infection. The facility failed to include these residents in the facility's infection control surveillance program. * The facility failed to ensure the clean laundry sorting table remained free of staff personal items. A laundry staff member's cell phone was observed on the clean laundry sorting table. * The facility failed to ensure Resident 26's clean gown was not stored on a soiled trash can lid. * The facility failed to ensure the CNA 8 cleaned and disinfected the call light prior to placing it on Resident 12's bed. * The facility to ensure LVN 7 donned proper PPE (gown) during management of Resident 107's GT feeding under enhanced barrier precautions. * The facility failed to ensure Resident 105's case of soda was not stored on the floor. * The facility failed to ensure CNAs performed hand hygiene during the delivery of the residents' meal trays. These failures posed the risk for not identifying resident infections, preventing resident infections, and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: 1. Review of the facility's P&P titled Infection Surveillance Outcome and Reporting revised 4/2025 showed it is the policy of the facility to maintain an ongoing system of surveillance designed to identify possible communicable diseases or infections to ensure that measures are taken to prevent any potential outbreaks. The charge nurse reports any residents displaying signs/symptoms (of infection) and the nature of the symptoms. The charge nurse will be responsible for recording the information of all residents displaying any symptoms of infection on the Infection Surveillance log. The Infection Surveillance Log is maintained by the Infection Preventionist (IP). The IP or designee will trend all validated infections using McGeer's criteria on a monthly basis. Action plans will be written for any identified problems and implemented as soon as possible. On 5/4/26 at 1021 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's infection surveillance program. The IP stated when a resident exhibited signs and/or symptoms of infection and was prescribed an antimicrobial medication, the facility would determine if the resident had met McGeer's criteria. The IP stated this information was documented on the facility's Infection Surveillance V-2 form. The IP then stated on a monthly basis he would determine how many residents in the facility had exhibited signs and/or symptoms of infection and were prescribed an antimicrobial medication. The IP stated he documented this information on the facility's monthly Infection Surveillance log. The IP stated in accordance with the facility's Infection Surveillance Outcome and Reporting P&P, the facility's Infection Surveillance program functioned to identify possible communicable diseases or infections, to ensure that measures were taken to prevent any potential outbreaks. Review of the facility's monthly Infection Surveillance Logs from April 2025 through February 2026 showed the following infection surveillance data for HAIs, CAIs, and residents who did not meet McGeer's criteria (DNMC): - for 4/2025, HAI - 32, CAI – 44, and DNMC – 6; (continued on next page)

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	05/06/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- for 5/2025, HAI - 24, CAI – 53, and DNMC -6; - for 6/2025, HAI - 35, CAI – 37, and DNMC -6; - for 7/2025, HAI – 25, CAI – 52, and DNMC – 13; - for 8/2025, HAI - 23, CAI – 38, and DNMC -10; - for 9/2025, HAI - 40, CAI – 46, and DNMC -11; - for 10/2025, HAI - 38, CAI – 38, and DNMC – 10; - for 11/2025, HAI - 40, CAI –46, and DNMC –11; - for 12/2025, HAI - 29, CAI – 37, and DNMC -7; - for 1/2026, HAI - 20, CAI – 30, and DNMC – 7; and - for 2/2026, HAI - 21, CAI – 37, and DNMC – 6. Further review of the facility's monthly Infection Surveillance Logs from April 2025 through February 2026 showed all the residents included on the Infection Surveillance logs were also prescribed antimicrobial medications. The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed antimicrobial medications, if the facility initiated the Infection Surveillance V-2 form (McGeer's criteria) for these residents and if these residents were included in the facility's infection surveillance program. The IP stated the facility did not initiate the Infection Surveillance V-2 form for residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications. The IP was asked how many residents in the facility had infections (met McGeer's criteria) and were not prescribed antimicrobial medications (from April 2025 through February 2026). The IP stated he was uncertain as the facility did not initiate the Infection Surveillance V-2 form (McGeer's criteria) for residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications. 2. Review of the facility's P&P titled Infection Prevention Linen Management (undated) showed clean linens are to be kept protected from dust and other contaminants prior to use. On 5/4/26 at 1009 hours, an observation and concurrent interview was conducted with Laundry 1. An observation of the facility's laundry room was conducted with Laundry 1. The counter designated for clean laundry sorting was observed with Laundry 1's cell phone on the countertop, adjacent to clean linens. Laundry 1 verified the findings and stated the cell phone should not be stored on the clean laundry sorting counter adjacent to resident clean linens, for infection control. 3. Medical record review for Resident 26 was initiated on 5/3/26. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/3/26 at 0900 hours, an observation and concurrent interview was conducted in Resident 26's room. A folded gown was observed stored on the lid of the soiled trash can in Resident 26's room. Resident 26 stated the staff routinely placed gowns, linens, and towels used for her care on the trash can before providing the morning care. (continued on next page)

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	05/06/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 26's H&P examination dated 4/14/26, showed Resident 26 had the capacity to make medical decisions. On 5/3/26 at 0915 hours, an interview and concurrent observation was conducted with CNA 8. CNA 8 stated the linen to be used during the resident's care should be placed on the resident's bedside table or the nightstand table. CNA 8 stated the linen not used during the care should go in the dirty linen hamper. CNA 8 stated Resident 26 just had her breakfast, and the morning care had not been provided yet. CNA 8 verified the above findings. CNA 8 stated the gowns should not be stored on top of the trashcan lid for infection control purposes. CNA 8 was observed removing the gown. 4. Medical record review for Resident 12 was initiated on 5/3/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/3/26 at 0923 hours, during the initial tour of the facility, Resident 12's call light was observed on the ground. On 5/3/26 at 0929 hours, an observation and concurrent interview was conducted with CNA 8. CNA 8 verified the above findings and was observed picking up Resident 12's call light and placing it on Resident 12's bed without disinfecting it. CNA 8 verified she did not disinfect the call light prior to placing it on the resident's bed. CNA 8 stated the call light should be cleaned and disinfected before placing it on the resident's bed for infection control purposes. On 5/6/26 at 0842 hours, an interview was conducted with the IP. The IP stated the linen, gowns, and towels, when not being used should be placed on the bedside drawer or inside the resident's closet. The IP stated the unused linen should go into the dirty linen container and should not be stored on top of the trashcan due to the potential contamination if used on the residents. The IP further stated when the call lights fall on the ground, it should be wiped with an approved disinfectant before placing it on the resident's bed or giving it to the resident to prevent transmission of microorganisms. On 5/6/26 at 1444 hours, an interview was conducted with the Administrator, DON, and Clinical Resource Nurse. The Administrator, DON, and Clinical Resource Nurse were informed and acknowledged the above findings. 5. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precaution revised 3/2024 showed enhanced barrier precaution: use in conjunction with standard precautions and expand the use of personal protective equipment (PPE) through the use of gowns and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents of from resident-to-resident. - Personal Protective Equipment (PPE): the use of gowns and gloves for high contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with indwelling medical devices include, but are not limited to central lines, peripherally inserted central catheter (PICC) lines, urinary catheter, feeding tubes, and tracheostomies. On 5/26/26 at 1213 hours, an observation and concurrent interview for Resident 107 was conducted with LVN 7. Resident 107's GT feeding was heard with an alarming sound. LVN 7 entered to the room, sanitized her hands and donned gloves. LVN 7 was observed turning off the Kangaroo pump (an enteral pump machine to deliver nutrition and hydration directly into a resident's gastrointestinal tract), touching the resident's blanket, disconnecting the GT tube from the resident, and then tucking (continued on next page)

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	05/06/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's blanket. When LVN 7 was asked if she needed to use a gown when she disconnected the GT feeding from resident, LVN 7 stated she did not use the proper PPE when she disconnected the GT but should have used the gown to prevent infection. Medical record review for Resident 107 was initiated on 5/3/26. Resident 107 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 107's MDS assessment dated [DATE], showed Resident 107's BIMS score of 2, indicating severe cognitive impairment. Review of Resident 107's Order Summary Report showed a physician's order dated 3/3/26, for enhanced barrier precautions: personal protective equipment (PPE) required for high contact care activities, indication indwelling medical device (feeding tube). On 5/6/26 at 1024 hours, an interview was conducted with the DON. The DON stated the staff should have used the proper PPE when caring for the residents who were on enhanced barrier precautions to prevent infection. The DON was informed and verified the above findings. On 5/6/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 6. Medical record review for Resident 105 was initiated on 5/3/26. Resident 105 was admitted to the facility on [DATE]. On 5/3/26 at 0950 hours, during an initial tour of the facility, an observation and concurrent interview was conducted with LVN 9 inside Resident 105's room. One case of soda was observed on the floor. LVN 9 verified findings and stated the resident's belongings should not be placed on the floor for infection control. On 5/3/26 at 1041 hours, an interview with the IP was conducted. The IP verified LVN 9 informed him of Resident 105's personal belongings on the floor. The IP stated Resident 105's case of soda should not have been kept on the floor to avoid pests and infection control. On 5/6/26 at 1430 hours, an interview with the Administrator, DON, Clinical Resource Nurse, and Dietary Resource was conducted. The Administrator, DON, Clinical Resource Nurse, and Dietary Resource were informed and acknowledged findings. 7. On 5/3/26 at 1310 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 was observed going into Room A and coming out of Room A without performing hand hygiene. CNA 3 was then observed grabbing meal trays to deliver to the residents. CNA 3 stated she repositioned the resident in Room A and fixed Room A's meal tray. CNA 3 further stated she washed her hands using the sink in Room A and dried her hands with paper towel. When asked to show where CNA 3 threw the paper towel, CNA 3 stated in the resident's trash bin but verified the trash bin was empty without a paper towel. CNA 3 verified she did not perform hand hygiene after providing care and before delivering the meal trays. On 5/3/26 at 1307 hours, an observation was conducted with CNA 4 during the delivery of lunch meal trays. CNA 4 observed delivering the lunch meal tray to multiple rooms but did not perform hand hygiene before and after delivery of the lunch meal trays. (continued on next page)

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	05/06/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/3/26 at 1332 hours, an interview was conducted with CNA 4. CNA 4 verified hand hygiene was not performed before and after delivering lunch meal trays to residents. CNA 4 stated he should have washed his hands before and after delivering the lunch meal trays. On 5/6/26 at 1458 hours, an interview was conducted with the DON, Clinical Resource and Administrator. The DON, Clinical Resource, and Administrator were informed and acknowledged the findings above.

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	05/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the staff provided care and promoted dignity and respect for one nonsampled resident (Resident 77). * The facility failed to ensure Resident 77's call light was answered in a timely manner. This failure had a potential for the resident's need to not be met as the call light was not answered timely and negatively affected the resident's well-being.Findings: Review of the facility's P&P titled Call Light dated 5/2007 showed call light is used to provide the resident a means of communication with nursing staff and to answer the light within a reasonable time, turn off the call light, listen to the resident's request or need. On 5/4/23 at 0914 hours, an observation for Room C was conducted. Room C was observed with a call light on. Multiple staff were observed passing by Room C, walked through the hallway and did not respond to Room C's call light. A minimal sound could be heard from the activated call light in the call light panel at Nurses' Station A with the staff coming in and out of Nurse Station A. On 5/4/26 at 0918 hours, a follow-up observation for Room C was conducted. Housekeeping 1 was observed by the doorway of Room C, donned a gown and went inside Room C. Room C call light remained lit. On 5/4/26 at 0919 hours, a follow-up observation was conducted of Nurses Station A. A facility staff including COTA 1 were observed going to Nurses Station A, then would pass by Room C without responding to the call light in Room C. On 5/4/26 at 0923 hours, AIT 1 went inside Room C and responded to the call light. On 5/4/25 at 0955 hours, an interview was conducted with Housekeeping 1. Housekeeping 1 verified the call light was on in Room C. Housekeeping 1 was asked if she was supposed to answer the call light activated by the residents, Housekeeping 1 responded, no, only to clean. On 5/4/26 at 0957 hours, an interview was conducted with CNA 6. CNA 6 stated she would answer the call light if she passed by and sees it, even if it was not her resident. CNA 6 also stated there was a notification by the nurses' station if a call light was activated. On 5/4/26 at 1157 hours, an interview was conducted with COTA 1. COTA 1 was asked who would respond to the call lights, COTA 1 stated, usually all staff would respond. COTA 1 further stated he remembered going to Nurses Station A and passed by Room C but did not look or see the call light was on. On 5/4/26 at 1550 hours, an interview and concurrent facility record review was conducted with the Administrator. The Administrator showed the electronic gadgets used by the facility to monitor the activated call light and showed as follows:- call light system monitor gadget attached to the medication nurse laptop, on the facility's medication carts;- a monitor screen by the nurse station showing an activated call light, and- the call light station on each nurse's station - lights up the activated call light location with a sound. Review of the call light log from 0900 to 0930 hours was conducted with the Administrator. The log showed Room C's call light was activated at 0914 hours, turned off, immediately reactivated, and then turned off at 0923 hours. The Administrator was made aware the call light log from 0900 hours to 0930 hours for Room C's call light was consistent with the observation. The Administrator was informed no staff were observed entering the room prior to 0918 hours, when Housekeeping 1 entered Room C to begin cleaning and eventually, the call light was turned off at 0923 hours by AIT 1. On 5/6/26 at 1338 hours, an interview was conducted with Resident 77 inside his room. Resident 77 was asked how he feels about the call light use and staff responses. Resident 77 stated it takes the staff a long time to respond and they think that I'm crazy, they come and they turn off the light, then they don't come back. Resident 77 stated he would need assistance in cleaning himself up, sometimes the tv won't turn on the right channel, and sometimes he would walk to the nurse's station to ask for coffee. Resident further stated, it's really not good, I feel bad calling, but I need help. Medical record review for Resident 77 was initiated on 5/6/26. Resident 77 was admitted to the facility on [DATE]. Review of Resident 77's MDS assessment dated [DATE], showed a BIMS score of 12 (moderately impaired cognition). Review of Resident 77's Care (continued on next page)

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	05/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan Report showed the following focused problems: - dated 2/7/26, for ADL Self-care Performance Deficit. The interventions included to encourage Resident 77 to use call light for assistance, and the transfer from chair to bed to chair and toilet required one person assist; and- dated 2/7/26, for risk to falls and injuries. The intervention included to ensure call light is within reach and encourage to use to call for assistance as needed. On 5/6/26 at 1615 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON were informed Resident 77's not being answered in a timely manner. The Administrator and DON acknowledged the findings.

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	05/06/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide a reasonable accommodation to meet the needs of one of 32 final sampled residents (Resident 54) and one nonsampled resident (Resident 147). * The facility failed to ensure Resident 54 and 147's call light was within the resident's reach. This failure had the potential to negatively impact the residents' psychosocial well-being and cause delays in receiving the needed care.Findings: Review of the facility's P&P titled Call Light/Bell revised 5/2007 showed to leave the resident comfortable. Place the call device within resident's reach before leaving room. If the call light/bell is defective, immediately report this information to the unit supervisor. 1. Medical record review for Resident 54 was initiated on 5/3/26. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's MDS assessment dated [DATE], showed Resident 54 had a BIMS score of 2 (severe cognitive impairment). Furthermore, the MDS assessment showed Resident 54 had one side impairment on upper extremity. On 5/3/26 at 0828 hours, an observation was conducted for Resident 54. Resident 54 was observed seated in a wheelchair on the left side of the bed. The resident's call light button was observed on the left side of the bed. However, the call light was positioned on the right side of the resident's wheelchair and not within Resident 54's reach. On 5/3/26 at 0840 hours, an observation for Resident 54 and concurrent interview was conducted with CNA 1. CNA 1 verified Resident 54 had right upper extremity mobility impairment and the call light button was too far for Resident 54 to reach. CNA 1 verified the call light was placed on the bed where Resident 54 could not reach using his left arm. 2. Medical record review for Resident 147 was initiated on 5/3/26. Resident 147 was admitted to the facility on [DATE]. Review of Resident 147's MDS assessment dated [DATE], showed Resident 147 had a BIMS score of 6 (severe cognitive impairment). On 5/3/26 at 0916 hours, an observation and concurrent interview was conducted with Resident 147. Resident 147's call light button was observed hanging on the left side of the headboard behind Resident 147. Resident 147 stated he could not locate his call light button. On 5/3/26 at 0925 hours, CNA 2 was called to Resident 147's room and an observation and concurrent interview was conducted with CNA 2. CNA 2 stated Resident 147 would call for help by pressing his call light button. CNA 2 verified the call light button was hanging on the left side of the headboard and Resident 147 could not reach the call light button. On 5/6/26 at 1458 hours, the DON, Clinical Resource, and Administrator were informed and acknowledged the findings above.

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	05/06/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to maintain a safe, clean, and homelike environment for two of 32 final sampled residents (Residents 26 and 48) and one nonsampled resident (Resident 117). * Resident 26 resided in Room D. The wall behind Resident 26's bed was observed in disrepair with black streak marks on the wall and chipped paint on the wall and wall trimmings. In addition, Resident 26's ceiling was observed with chipped and peeling paint. * Resident 48 resided in Room E. The wall behind Resident 48's head of bed was observed in disrepair with chipped paint and cracked wall trims. * The walls and bathroom door in Resident 117's room were observed in disrepair. These failures had the potential to negatively impact on the residents' quality of life. Findings: 1. Medical record review for Resident 26 was initiated on 5/3/26. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/3/26 at 0900 hours, Resident 26 was observed lying in bed in Room D. A white thin panel was observed hanging from the ceiling to the right of Resident 26's bed. A cord was observed between the thin panel and connected to the electrical power strip. The ceiling was observed with chipped and peeled paint. Additionally, the wall behind Resident 26's head of bed was observed with black vertical streak marks and chipped paint on the wall and wall trimming. On 5/5/26 at 1011 hours, an interview and concurrent observation of Room D was conducted with LVN 6. LVN 6 verified the above findings and stated the ceiling needed to be painted and she did not know what the black streak marks were. LVN 6 further stated the residents should have a homelike environment in their rooms. On 5/6/26 at 0930 hours, an interview was conducted with Resident 26. Resident 26 stated after looking at the ceiling her visitor asked her if the facility was falling apart. 2. Medical record review for Resident 48 was initiated on 5/3/26. Resident 48 was admitted to the facility on [DATE]. On 5/5/26 at 1419 hours, an interview and concurrent observation was conducted with Resident 48 in Room E. Resident 48 was observed lying in bed. The wall behind Resident 48's head of bed was observed in disrepair with chipped wall trimmings and chipped/peeling paint on the wall. On 5/6/26 at 1010 hours, an interview and concurrent observation of Room E was conducted with LVN 6. LVN 6 verified the above findings. On 5/6/26 at 1049 hours, an interview was conducted with the DON. The DON stated the facility should promote a homelike environment as much as possible. The DON stated the facility was in process of repairing rooms in need of repairs. On 5/6/26 at 1444 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. (continued on next page)

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	05/06/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Medical record review for Resident 117 was initiated on 5/6/26. Resident 117 was admitted to the facility on [DATE]. On 5/6/26 at 1055 hours, an observation and concurrent interview was conducted with Resident 117. Resident 117 was observed in her room (Room B) sitting in a wheelchair. The wall and bathroom door adjacent to Resident 117's bed was observed in disrepair, as evidenced by scratches and chipped paint. When Resident 117 was asked to describe the condition of her room, Resident 117 stated the entire room needed to be painted. On 5/6/26 at 1600 hours, an interview was conducted with the DON. The DON stated the facility was in the process of repairing the residents' rooms in need of repairs.

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	05/06/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide a copy of the notification of the transfer/discharge to the Office of the State Long-Term Care Ombudsman for one of the two residents (Resident 7) who were transferred to the acute care hospital. * The facility failed to ensure copy of the transfer discharge notification was sent to the Ombudsman when Resident 7 was transferred to the acute care hospital on 2/24/26. This failure had the potential for the resident to not receive additional protection when the residents was being inappropriately transferred or discharged .Findings: Review of the facility's P&P titled Criteria for Transfer and Discharge revised April 2025 showed the facility shall send a copy of the notice to the State Long-Term Care Ombudsman. The notice shall be made at least 30 days before the resident transferred or discharged or as soon as practicable before transfer or discharge when:- The safety or health of individuals in the facility would be endangered;- The resident's health improves to allow a more immediate transfer or discharge;- An immediate transfer or discharge is required by the resident's urgent need; or- A resident has not resided in the facility for 30 days. Closed medical record review for Resident 7 was initiated on 4/23/26. Resident 7 was admitted to the facility on [DATE], and transferred to the acute care hospital on 2/24/26. Review of Resident 7's Physician Order Summary showed a physician's order dated 2/24/26, to transfer Resident 7 to the acute care hospital for further evaluation due to altered mental status and facial drooping and bed hold for seven days if admitted . Review of Resident 7's Notice of Proposed Transfer/Discharge form showed Resident 7's name and other information on the form was not filled out. Further review of Resident 7's medical record failed to show documented evidence the Ombudsman was notified of Resident 7's transfer to the acute care hospital. On 5/5/26 at 1042 hours, an interview and concurrent closed medical record review for Resident 7 was conducted with the MRD. The MRD reviewed Resident 7's Notice of Proposed Transfer/Discharge form and verified the form was not completed. The MRD stated when transferring a resident, the charge nurse had to fill out the Notice of Proposed Transfer/Discharge form and fax the form to the Ombudsman. The MRD verified the notice was not sent to Ombudsman. The MRD further stated the facility should have sent the notice so the Ombudsman would have a record of the resident's being sent to the acute care hospital. On 5/6/26 at 1430 hours, an interview was conducted with the DON and Administrator. The DON and the Administrator was informed and acknowledged above findings.

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	05/06/2026

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and document review, the facility failed to ensure the PASRR Level 1 screening was accurate for one of four final sampled residents (Resident 94) reviewed for PASRR. * Resident 94 had diagnosis of psychosis, however, the PASRR Level 1 screening showed Resident 94 had no diagnosis of serious mental illness and had no psychotropic medication. This failure had the potential risk for Resident 94 not to receive the necessary care and services due to inaccurate assessment.Findings: Review of PASRR screening background statement showed the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) and 42 Code of Federal Regulations Sections 483.100 through-483.138 requires that each individual, including, but not limited to, an applicant and resident, regardless of payment source, applying for admission to, or residing in, a Medicaid-certified Nursing Facility (NF) be screened and evaluated for serious mental illness and intellectual disability, developmental disability and related condition(s). Federal law prohibits payment for Nursing Facility services until the PASRR screening has been completed. Medical record review for Resident 94 was initiated on 5/3/26. Resident 94 was admitted to the facility on [DATE]. Review of Resident 94's H&P examination dated 12/26/25, showed Resident 94 had no capacity to make medical decisions. Review of Resident 94's PASRR Level 1 screening dated 12/17/25, showed Resident 94 had no diagnosis of mental illness and no prescribed psychotropic medications. The form further showed the Level 1 screening was negative and a Level 2 evaluation was not required because the resident did not have a serious mental illness. Review of Resident 94's Face Sheet dated 5/5/26, showed under the Diagnosis Information section, the resident had unspecified psychosis not due to a substance or known physiological condition. Review of Resident 94's Order Summary Report dated 5/5/26, showed a physician's order dated 12/24/25, to administer Seroquel (antipsychotic) 25 mg one tablet by mouth two times a day for psychosis as manifested by combative behavior. On 5/4/26 at 1128 hours, an interview and concurrent medical record review for Resident 94 was conducted with the MDS Assistant. The MDS Assistant verified the above findings and stated the Level 1 PASSR screening was inaccurate and a resident review should have been completed because Resident 94 had a serious mental illness diagnosis and was prescribed a psychotropic medication. On 5/6/26 at 1458 hours, an interview was conducted with the DON, Clinical Resource, and Administrator. The DON, Clinical Resource, and Administrator were informed and acknowledged the findings above.

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	05/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive, person-centered care plan was developed and implemented for four of 32 final sampled residents (Residents 1, 12, 13, and 94). * The facility failed to develop a comprehensive, person- focused care plan addressing Resident 1's noncompliance with the prescribed dietary regimen. * The facility failed to develop the comprehensive, person-centered care plan to address Resident 12's hemodialysis treatments, fluid restrictions, hemodialysis access monitoring, and nutrition status. * The facility failed to develop a care plan to address Resident 13's use of a low air loss mattress (LAL). * The failed to develop a care plan to address and support Resident 94's care needs related the resident's diagnosis of dementia. These failures had the potential to result in inconsistent, inappropriate or non-individualized care for Residents 1, 12, 13, and 94.Findings: Review of the facility's P&P titled Comprehensive Resident Centered Care Plan dated April 2025 showed it is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 1. On 5/3/26 at 0929 hours, Resident 13 was observed lying in bed on the LAL mattress. Medical record review was initiated on 5/4/26. Resident 13 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 13's Order Summary Report showed a physician's order dated 3/16/26, for use of a LAL mattress for skin maintenance, including monitoring proper function and setting every shift. Setting to be based on the resident's weight then comfort. On 5/4/26 at 1015 hours, an interview and concurrent medical record review for Resident 13 was conducted with the MDS Assistant. The MDS Assistant verified there was no care plan addressing the resident's LAL mattress use on or after 3/16/26. On 5/6/26 at 1445 hours, an interview with the DON and Administrator was conducted. The DON and Administrator were informed and acknowledged the above findings. 2. On 5/3/26 at 910 hours, during the facility tour, Resident 1's room was observed with two small unopened bags of chips on the windowsill and an open box containing small packs of chips inside Resident 1's open closet. Further review of label information of Doritos Nacho Cheese tortilla chips one ounce bag contained 170 mg of sodium, 7 % of daily value and Doritos Cool Ranch flavor tortilla chips showed a one-ounce bag contained 160 mg of sodium, 7 % of daily value. Medical record review for Resident 1 was initiated on 5/4/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 4/6/25, showed Resident 1 could make needs known and medical decisions at this time. (continued on next page)

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	05/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's nutrition care plan showed the following interventions: - dated 3/14/26, to monitor and honor residents' rights to make personal dietary choices and provide dietary education as needed; and - dated 3/14/26, to monitor and report to MD as needed for any signs and symptoms of decreased appetite. Review of Resident 1's Order Summary Report dated 5/4/26, showed a physician's order dated 4/16/26, for a NAS (No Added Salt) regular diet, level seven texture, thin liquids. On 5/4/26 at 0815 hours, an interview was conducted with CNA 9. CNA 9 stated Resident 1 had many bags of chips and soda brought in by a friend. CNA 9 further stated he fed the resident chips when requested. On 5/4/26 at 9025 hours, an interview and concurrent medical record review was conducted with RD 2. RD 2 reviewed Resident 1's diet orders and acknowledged Resident 1's consistent chip consumption was not addressed in the Nutrition Care Plan and stated, I will follow up. On 5/4/26 at 1207 hours, an interview and concurrent medical record review was conducted with Case Manager 2. Case Manager 2 reviewed Resident 1's medical record and verified Resident 1's frequent eating of chips was not addressed in the resident's care plan, despite the NAS diet. On 5/6/26 at 1615 hours, an interview with the Administrator and DON was conducted. The Administrator and DON were informed and acknowledged the findings. 3. On 5/3/26 at 0923 hours, an interview was conducted with Resident 12. Resident 12 stated he was on fluid restrictions and received hemodialysis treatments every Tuesday, Thursday, and Saturdays. Resident 12 was able to show his hemodialysis access on the left arm. Medical record review for Resident 12 was initiated on 5/3/26. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's H&P examination dated 4/26/26, showed Resident 12 had the capacity to make medical decisions. Review of Resident 12's Order Summary Report dated 5/5/26, showed the following physician's orders: - dated 4/26/26, to assess Resident 12's left arteriovenous (AV) fistula shunt (a surgically created connection between and artery and vein for hemodialysis treatments) site for bruit (a turbulent whooshing sound heard with a stethoscope over a blood vessel) and thrill (the palpable vibration felt with your fingers in the same location), every shift; and to document + (positive) or – (negative) for the presence of bruit and thrill. To call the physician for absences. - dated 4/26/26, to assess Resident 12's shunt/dialysis site every shift and document the following: C= clear, T= tenderness, R= redness, B= bleeding, every shift. - dated 4/29/26, for Resident 12 to receive the hemodialysis treatments every Tuesday, Thursday, (continued on next page)

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	05/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Saturdays with Dialysis Center A. - dated 4/29/26, for Resident 12 to have a total fluid restriction of 1500 ml per day from dietary and nursing. The total nursing fluids of 420 ml per day: for the 0700 to 1500 hours shift = 160 ml, 1500 to 2300 hours shift= 160 ml, and 2300 to 0700 hours shift = 100 ml, every shift. - dated 4/29/26, total fluid restriction of 1500 ml per day. 1080 ml dietary fluid per day. Breakfast = 260 ml, Lunch = 360 ml, and Dinner = 360 ml, after meals. - dated 4/29/26, for Resident 12 to receive a regular renal diet- level 7 texture, thin liquids-level 0 consistency. Review of Resident 12's plan of care failed to show a care plan was formulated to address Resident 12's nutrition, fluid restrictions, hemodialysis treatment, and the monitoring of Resident 12's hemodialysis access. On 5/5/26 at 1030 hours, an interview and concurrent medical record review for Resident 12 was conducted with LVN 6. LVN 6 stated Resident 12 received hemodialysis treatments every Tuesdays, Thursday, and Saturdays. LVN 6 stated Resident 12 was on fluid restrictions of 1500 ml per day. LVN 6 reviewed Resident 12's medical record and verified the above findings. On 5/6/26 at 1049 hours, an interview was conducted with the DON. The DON stated the purpose of the comprehensive care plans was to guide the provisions of the resident's care while the resident was at the facility. The DON stated upon admission to the facility, the admitting nurse would initiate the care plan, and the care plan would be revised quarterly and as needed. The DON stated the care plans should be individualized for each resident The DON further stated for a resident receiving hemodialysis treatments, there should be a care plan problem to address the residents hemodialysis treatments, hemodialysis access site monitoring, nutritional status, and fluid restrictions. On 5/6/26 at 1444 hours, an interview was conducted with the Administrator, DON, and Clinical Resource Nurse. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Dementia Care Policy/ Procedure revised 01/2021 showed develop and implement person-centered care plans that include and support the dementia care needs, identified in the comprehensive assessment and on quarterly and annual basis, the IDT shall review and revise care plans that have not been effective and/or when the resident has a change in condition. Medical record review for Resident 94 was initiated on 5/3/26. Resident 94 was admitted to the facility on [DATE]. Review of Resident 94's H&P examination dated 12/26/25, showed Resident 94 had no capacity to make medical decisions and diagnosis of dementia. Review of Resident 94's Care Plan Report (undated) showed no care plan addressing dementia or dementia-related needs had been developed for the resident. On 5/3/26 at 1056 hours, a telephone interview was conducted with Family 1. Family 1 stated (continued on next page)

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	05/06/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 94 had dementia and expressed concerns about communication breakdown among the facility staff regarding how to care for the resident. On 5/5/26 at 1409 hours, an interview was conducted with CNA 5. CNA 5 stated Resident 94 was forgetful and did not exhibit negative behaviors. CNA 5 further stated she communicated with Resident 94 calmly while providing care and allowed him plenty of time to respond. On 5/5/26 at 1451 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 stated care planning began upon admission and should be reviewed and revised quarterly and as needed. RN 1 verified Resident 94 did not have a person-centered care plan with measurable goals and interventions addressing dementia care needs since the resident's admission on [DATE]. RN 1 stated Resident 94 was scheduled for a care plan meeting in March 2026 but verified the only care plan meeting held was on 12/20/25. On 5/6/26 at 1458 hours, an interview was conducted with the DON, Clinical Resource, and Administrator. The DON, Clinical Resource, and Administrator were informed and acknowledged the findings above.

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	05/06/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plans of care for two of 32 final sampled residents (Residents 53 and 98) was revised to reflect the resident's current care needs and interventions. * Resident 53's care plan was not updated to reflect the resident's care needs and interventions. * Resident 98's plan of care was not revised to reflect resident's care needs and interventions. These failures posed the risk of not providing Residents 53 and 98 with individualized and person-centered care.Findings: Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 8/2019 show it is the policy of this facility that the Interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.- the resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment. 1. Medical record review for Resident 53 was initiated on 5/3/26. Resident 53 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Residents 53's MDS 5-day PPS (prospective payment system - a Medicare payment method where providers are paid a set amount based on diagnosis, rather than the cost of treatment) assessment dated [DATE], showed Resident 53's BIMS summary score was 9 (moderate cognitive impairment). Review of Resident 53's Care Plan Report failed to show that plan of care for the resident was reviewed and updated. On 5/5/26 at 0954 hours, an interview and concurrent medical record review for Resident 53 was conducted with LVN 2. LVN 2 verified resident's care plan was not revised nor updated on target date of 5/1/26. 2. Medical record review for Resident 98 was initiated on 5/3/26. Resident 98 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Residents 98's MDS annual assessment dated [DATE], showed Resident 98's BIMS summary score was 15 (meaning cognitively intact). Review of Resident 98's Care Plan Report failed to show that plan of care for the resident was reviewed and updated. On 5/4/26 at 1316 hours, an interview and concurrent medical record review for Resident 98 was conducted with RN 1. RN 1 verified the resident's care plan was not revised nor updated on target date of 4/29/26. On 5/6/26 at 1024 hours, an interview was conducted with the DON. The DON was asked regarding updating the care plan. The DON stated the care plan were the guide of the facility in providing care to the residents and need to be updated and revised if the intervention was effective or not. The DON verified that Residents 53 and 98 care plan was not updated nor revised. On 5/6/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	05/06/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and the facility P&P review, the facility failed to ensure the appropriate services needed to maintain the acceptable parameters of nutritional status were provided for one of five final sampled residents (Resident 53) reviewed for nutrition. * The facility failed to ensure the RD and IDT analyzed and implemented the necessary interventions and the physician and resident and/or their representative were notified when Resident 53's had unplanned significant weight loss of 16 lbs. (8.04%) between 4/4 and 5/2/26. In addition, Resident 53's resident-centered care plan was not revised to address Resident 53's severe weight loss of 16 lbs. These failures had the potential for Residents 53 to not receive the necessary intervention to prevent further weight loss.Findings: Review of the facility's P&P titled Nutrition Status Management revised on 4/2025 showed it is the policy of this facility to assess each resident's nutritional status and needs, including medications and medical conditions to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and other available data, unless the resident's clinical condition demonstrates that this is not possible. The P&P showed the following sections:1. Assessment showed each resident is to be weighed upon admission, then weekly weights for four (4) weeks and monthly weight thereafter. The weight will be entered directly into the electronic health record. (POC/PCC(Point of Care/Point ClickCare), and monthly weights are to be taken starting the first day of the month. Monthly and weekly weights are reviewed by the DNS (Director of Nursing Services)/designee;2. Dietary Evaluation showed if there is a significant change in the resident's condition related to weight or nutrition, the Registered Dietician (RD) will make recommendation to offer additional nutrition to those residents including all high-risk residents. Options include, but are not limited to, fortified cereal, large portions, between meal snacks and commercial nutritional supplements.3. Clinical Evaluation showed any weight that varies from the previous reporting period by more than 5% in 30 days and 10% in 180 days will be evaluated by the Interdisciplinary Team (IDT) to determine the cause of weight loss/gain and intervention required, the nurse will notify the physician, family and/or resident of the weight loss/gain with interventions, and any resident meeting the criteria for weight loss and any resident at risk will be weighed weekly with the weight entered into POC/PCC(Point of Care/Point ClickCare). Weekly weights will be reviewed by the Registered Dietitian (RD)/designee. Medical record review for Resident 53 was initiated on 5/3/26. Resident 53 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Residents 53's MDS assessment dated [DATE], showed Resident 53's BIMS summary score was 9 (moderate cognitive impairment). Review of Resident 53's Weight Summary showed the following dates and weights:- dated 4/4/26, 199 lbs;- dated 4/13/26, 195 lbs; a weight loss of 4 lbs from 4/4/26;- dated 4/18/26, 192 lbs; a weight loss of 7 lbs from 4/4/26;- dated 4/25/26, 188 lbs, a weight loss of 11 lbs or 5.5% from 4/4/26; and- dated 5/2/26, 183 lbs, a weight loss of 16 lbs or 8.04% from 4/4/26. Review of Resident 53's Order Summary report showed a physician's order dated 4/13/26, for a regular soft and bite sized diet, with thin liquid. Review of Resident 53's Nutrition Evaluation note dated 4/10/26, showed Resident 53's goal was to maintain the weight of 189 to 199 lbs. Review of Resident 53's medical record failed to show a change of condition was documented, the physician and resident/or responsible party was informed when the Resident 53 has a weight loss of 16 lbs. or 8.04% in 28 days. Further review of Resident 53's medical record failed to show a care plan was initiated to address Resident 53's weight loss. On 5/3/26 at 0923 hours, an observation and concurrent interview were conducted with Resident 53. Resident 53 was observed in bed with a breakfast tray on the overbed table. Resident 53 stated that she did not want to eat breakfast and only wanted to drink her glass of milk. On 5/4/26 at 0929 hours, an observation and concurrent interview for Resident 53 was conducted with CNA 10. Resident 53 was observed in bed holding her glass of milk and only wanted to eat the bread. CNA 10 stated Resident 53 did not like the food in the facility and only wants to eat the (continued on next page)

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	05/06/2026

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bread with cheese and soup. On 5/5/26 at 1008 hours, an interview for Resident 53 was conducted with RD 2. RD 2 was asked if she was aware of Resident 53's 16 lbs weight loss in 28 days. RD 2 stated she was only made aware of Resident 53's weight loss today. RD 2 further stated that she was still in training and there was an RD who was doing the RD/Nutritional assessment remotely. On 5/5/26 at 1015 hours, an interview and concurrent medical record review for Resident 53 was conducted with LVN 2. LVN 2 verified and stated when a resident had 16 lbs weight loss, an eINTERACT change of condition should have been made and communicated to the resident's physician and responsible party. LVN 2 further stated the Registered Dietitian (RD) should have assessed the resident's weight loss and a care plan should have been implemented. On 5/6/26 at 1024 hours, an interview was conducted with the DON. The DON was asked regarding significant weight loss of a resident, stated a 5 lbs and above weight loss was a significant weight loss. The DON stated a change of condition documentation should have been done, and the resident's physician and responsible party should have been notified. The DON stated the RD should have assessed Resident 53 and a care plan should have been implemented for weight loss. The DON further stated a change of condition for the weight loss should have been done since last week. The DON acknowledged the above findings. On 5/6/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	05/06/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary GT care and services for one of three final sampled residents (Resident 164) reviewed for enteral feeding care. * The facility failed to ensure Residents 164 was administered the total amount of the enteral feeding as ordered by the physician. This failure posed the risk of developing complications related to the enteral feeding.Findings: 1. Review of the facility's P&P titled Enteral Feeding Administration revised 5/2020 showed it is the policy of this facility to administer enteral feeding at a constant controlled infusion rate per physician's order. Intermittent delivery schedules are recommended. Medical record review for Resident 164 was initiated on 5/3/26. Resident 164 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident MDS annual assessment dated [DATE], showed Resident 164's Cognitive Skills for Daily Decision Making severely impaired. Review of Resident 164's Order Summary Report showed a physician's order dated 4/29/26, to administer Glucerna 1.2 (an enteral feeding formula) at 60 ml per hour for 20 hours or until volume limit is completed to provide 1200 ml/1440 kcal via GT, restart feeding at 1600 hours. On 5/3/26 at 1010 hours, Resident 164 was observed in bed with a GT feeding hanging and connecting via a feeding pump. The feeding formula was full, with a label showing Glucerna 1.2 (a full bag had a total of 1500 ml) and dated as administered from 5/3/26 at 0630 hours for 60 ml per hour for 20 hours. The feeding bag was still full and running. On 5/3/26 at 1027 hours, an observation for Resident 164 and concurrent interview was conducted with LVN 1. LVN 1 verified the above findings. The bag of Glucerna 1.2 (enteral feeding formula) connected to the GT pump machine was full and the GT pump machine was running. When asked to show the total amount of feeding given to Resident 164, LVN 1 showed the total amount fed was 1850 ml (order was 1200 ml for 20 hours). LVN 1 stated this was incorrect and further stated Resident 164 did not get the total amount of the GT feeding. On 5/6/26 at 1024 hours, an interview was conducted with the DON. The DON verified the above findings. On 5/6/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	05/06/2026

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for one of one final sampled resident (Resident 107) reviewed for IV therapy, consistent with the professional standards of practice. * The facility failed to ensure Resident 107's IV tubing was correctly labeled. In addition, the facility failed to develop a care plan for the use of an IV antibiotic therapy cefepime (medication used to treat serious bacterial infection including urinary tract infection). These failures posed the risk for the resident to develop complications related to the IV therapy.Findings: 1. Review of the facility's P&P titled Antibiotic Infusion Guideline (undated) showed closely observe and monitor the resident during the first and second doses for any sign of allergic reactions. Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised 8/2019 showed the baseline care plan will include minimum healthcare information necessary to properly care for a resident. During the initial tour of the facility on 5/3/26 at 0938 hours, Resident 107 was observed in bed awake, with peripheral IV line to right hand area, and was dated 4/26 (meaning 4/26/26). The IV bag has a date of 5/2/26, however, there was no time and initial of the nurse who hung the IV. In addition, the IV tubing had no label, was undated, no time when it was changed, and no initial of the nurse. On 5/3/26 at 0945 hours, an observation and concurrent interview were conducted with the DON. The DON verified the above findings and stated that when a licensed nurse hangs an IV medication, the nurse was required to label the IV bag and tubing with the date, time, and initials to prevent infection. Medical record review for Resident 107 was initiated on 5/3/26. Resident 107 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 107's MDS quarterly assessment dated [DATE], Resident 107's BIMS summary score of 2 (meaning severe cognitive impairment). Review of Resident 107's Order Summary Report showed a physician's order dated 4/27/26, for cefepime one gram, to give intravenously one time a day for urinary tract infection until 5/7/26. Review of Resident 107's care plan failed to show a care plan problem was developed to address the risk associated with the use of cefepime IV antibiotic. Further review of Resident 107's medical record failed to show a documentation of the side effect of the cefepime IV antibiotic was monitored. On 5/4/26 at 1131 hours, an interview and medical record review was conducted with LVN 2. LVN 2 stated a care plan should have been developed when the physician ordered the cefepime medication to monitor the side effect of the medication. LVN 2 verified the above findings. On 5/6/26 at 1446 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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	05/06/2026

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. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure safe and effective pharmaceutical services was provided for one of four residents (Resident 85) observed for medication pass and the proper accounting procedures of controlled substances was provided for two residents (Residents 90 and 193) reviewed for controlled substances reconciliation. * The facility failed to ensure medication for Resident 85 was administered in accordance with the prescriber's orders. This failure resulted in a medication error and had the potential to negatively affect the resident's health conditions. * The facility failed to ensure the RX Number was documented on the Controlled Substances Log for the bottles of morphine sulfate liquid solutions for Residents 90 and 193 which were stored in Medication Cart B. This failure had the potential for the facility to be unable to trace the movement of the scheduled drugs and identify discrepancies, prevent diversion, and ensure compliance with government regulations. Findings: 1. Review of the facility's P&P titled Guidelines for Medication Administration reviewed on 4/10/26, showed the following guidelines will be observed in the administration of all medications. Under the section for Procedure showed, to observe the five rights of administering the medication.The right dose. Review of Resident 85's Order Summary Report showed a physician's order dated 3/14/26, to give one tablet of calcium carbonate (calcium supplement) 600 mg combined with cholecalciferol (vitamin D3) 10 mcg by mouth two times a day as a supplement. On 5/4/26 at 0830 hours, a medication administration observation for Resident 85 was conducted with LVN 8. LVN 8 prepared and administered to Resident 85 one tablet containing both calcium 600 mg and cholecalciferol (vitamin D3) 5 mcg. On 5/4/26 at 1137 hours, an interview and concurrent record review for Resident 85 was conducted with LVN 8. LVN 8 stated they administered to Resident 85 one tablet containing both calcium 600 mg and cholecalciferol 5 mcg. LVN 8 reviewed Resident 85's medical record and verified Resident 85 had a physician's orders for calcium carbonate 600 mg combined with cholecalciferol 10 mcg. LVN 8 stated Resident 85 was administered with calcium 600 mg with cholecalciferol 5 mcg instead of cholecalciferol 10 mcg as ordered by the physician. On 5/6/26 at 1150 hours, an interview was conducted with the DON. The DON stated the expectation for medication nurse was to verify the medication prior to the medication administration. 2. Review of the facility's P&P titled Q Shift Controlled Drug Reconciliation reviewed on 4/10/26, showed controlled drug quantities will be verified and reconciled at the change of each nursing shift. At the completion of each nursing shift the on-coming and off-going nurses will count and reconcile controlled drugs subject to regulations and/or facility polices for individual counts. Each nurse will sign that such counts on a form. On 5/5/26 at 1450 hours, an observation of Medication Cart B, record review of the Controlled Substances Log and concurrent interview was conducted with LVN 8. When the Medication Cart B was inspected, the blue book containing the Controlled Substances Log was missing the RX Number for the two bottles of liquid morphine sulfate (pain medication) solutions. One bottle was for Resident 90 (on page 217) and another bottle for Resident 193 (on page 197) which were stored in Medication Cart B. On 5/6/26 at 0958 hours, an interview and document review was conducted the DON. The DON verified pages 197 and 217 of the blue book containing the Controlled Substances Log were missing the RX Number on pages 197 and 217 for the liquid morphine sulfate solutions for Residents 90 and 193. The DON stated the incoming and outgoing medication nurses uses the blue book for reconciliation of the controlled substances. The DON stated the purpose of the RX Number was to identify the medication.

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	05/06/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review and facility document review, the facility failed to ensure the Pharmacy Consultant's recommendation was acted upon for one of five residents (Resident 3) reviewed for unnecessary meds. * The facility failed to ensure Resident 3's continued use of the trazodone(antidepressant) and escitalopram (antidepressant) medications had a clinical rationale as per the Pharmacy Consultant recommendation. This failure had the potential to put Resident 3 at risk for adverse consequences related to the medications.Findings: Review of the facility's P&P titled Medication Drug Regimen Review dated 4/2025 showed if there is no change in the resident's medication during medication regimen review, the attending physician will document the rationale on the resident's medical record.Review of Resident 3's Note To Attending Physician/Prescriber dated 4/4/26, showed Resident 3 was currently prescribed with trazodone and escitalopram medications.to consider managing the resident's depression with a single antidepressant, if clinically appropriate. If continuation of dual therapy was indicated, to document the clinical rationale. Further review of the form showed an MD Response to continue the dual antidepressant therapy; however, the form failed to show documentation of the clinical rationale for the use of dual antidepressant therapy. The form was signed and dated by the physician on 4/13/26. Medical record review for Resident 3 was initiated on 5/5/26. Resident 3 was admitted to the facility on [DATE].Review of Resident 3's Care Plan Report initiated on 3/19/26, showed Resident 3 had impaired cognitive function/dementia or impaired thought processes related to Dementia.Review of Resident 3's Order Summary Report dated 5/5/26, showed a physician's order for the following antidepressant medications:- dated 5/1/26, to give escitalopram oxalate tablet 10 mg, one tablet one time a day for depression; and- dated 3/19/26, to give trazodone oral tablet 50 mg one tablet by mouth at bedtime for depression. Review of Resident 3's H&P examination dated 4/20/26, failed to show documentation supporting the continued use of dual antidepressant therapy with trazodone and escitalopram medications. Review of Resident 3's physician's progress notes did not show documentation of the clinical justification for the ongoing use of dual antidepressant therapy trazodone and escitalopram medications. On 5/5/26 at 1540 hours, an interview and concurrent record review for Resident 3 was conducted with LVN 2. LVN 2 verified Resident 3's Note To Attending Physician/Prescriber dated 4/4/26, and the physician's/nurse practitioner's progress notes failed to show documentation of the clinical rationale for the continued use of dual antidepressant therapy with trazodone and escitalopram medications. LVN 2 stated the rationale for the use of dual antidepressant therapy was not there. LVN 2 further stated, we usually call the doctor and when they come to sign, they write whatever was needed. On 5/6/26 at 1615 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON were informed regarding Resident 3's continued use of trazodone and escitalopram medications without a clinical rationale. The Administrator and DON acknowledged the findings.

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	05/06/2026

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five sampled residents (Resident 7) reviewed for unnecessary medication was free from the unnecessary medications. * The facility failed to ensure Resident 7's heart rate was monitored for the use of the amiodarone (medication to treat irregular or fast heartbeats) as ordered by the physician. This failure had the potential for the resident to receive unnecessary medication and put the resident at risk for adverse side effects. Findings: Review of the facility's P&P titled Guidelines for Medication Administration (undated) showed to observed the resident for immediate reaction and any reactions that occur during the hours following administration and record relevant and required information on the appropriate documentation record. Medical record review for Resident 7 was initiated on 5/5/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 3/4/26, showed Resident 7 had no capacity to understand and make decisions due to dementia. Review of Resident 7's Physician Order Summary dated 5/5/26, showed a physician's order dated 3/3/26, to give one tablet of amiodarone HCL oral tablet 200 mg by mouth one time a day for hypertension (high blood pressure), give with food and hold if the heart rate was less than 60 beats per minute. Review of Resident 7's MAR for May 2026 showed Resident 7 was administered with the amiodarone medication; however, there was no evidence to show the heart rate was monitored and documented. On 5/5/26 at 1030 hours, a review of Resident 7's MAR for May 2026 and concurrent interview was conducted with LVN 4. LVN 4 verified there were no heart rate documented on Resident 7's MAR for May 2026. LVN 4 further stated Resident 7's heart rate should have been monitored and documented in the MAR as per physician's order. LVN 4 verified the above findings. On 5/5/26 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed the heart rate of Resident 7 was not monitored as per the physician's order. The Administrator and DON acknowledged the findings.

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	05/06/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and facility document review, the facility failed to ensure food prepared in the facility kitchen was appealing and palatable when three of 153 residents (Residents 6, 12, and 94) expressed dissatisfaction with the taste of the food served. * The facility failed to ensure the potatoes served on the test tray was palatability. This failure posed the risk of the residents not receiving palatable and appetizing meals from the facility kitchen.Findings: Review of the facility's document titled Spring Cycle Menus dated 5/4/26, showed the regular menu for lunch menu included tarragon chicken with sauce, oven roasted potatoes, green beans with red peppers, broccoli salad, and tropical fruit mold. On 5/3/26 at 0923 hours, during the initial tour of the facility, Resident 12 stated the food does not taste good. On 5/3/26 at 1200 hours, during dining observation, Resident 6 stated the food was a bit bland. On 5/3/26 at 1324 hours, during dining observation, Resident 94 stated food tastes very old. On 5/4/26 at 1328 hours, an interview and concurrent test tray evaluation of the regular menu was conducted with the DSS, RD 2, and five surveyors present. The DSS, RD 2, and five surveyors verified the potatoes served were bland. On 5/6/26 at 1430 hours, an interview was conducted with the Administrator, DON, Clinical Resource Nurse, and Dietary Resource. The Administrator, DON, Clinical Resource Nurse, and Dietary Resource were informed and acknowledged the above findings.

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	05/06/2026

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, facility documents review, and facility P&P review, the facility failed to ensure two nonsampled residents (Resident 175 and 194) out of 153 residents receiving a lunch tray were provided meals in accordance with the residents documented food preferences. * The facility failed to ensure Resident 175 did not receive vegetables on her lunch tray, as per the resident's documented preference. * The facility failed to ensure Resident 194 did not receive apple juice on her lunch tray, as per the resident's documented preference. These failures had the potential to affect the residents not receiving meals consistent with their preferences. Findings: Review of the facility document titled Diet Type Report revised on 5/4/26, showed 153 residents received food from the kitchen. Review of the facility's P&P titled Nutrition Status Management revised 4/2025 showed diet evaluations will include determining ideal body weight range, usual body weight, current diet order, percentage of food eaten, possible dental problems, current illness, resident likes and dislikes, psychosocial needs, and any other change in medical condition that may impact weight gain or loss. a. On 5/4/26 at 1215 hours, an observation and concurrent interview was conducted with RD 1 during tray line observation. Resident 175's meal ticket showed a documented dislike for all vegetables. An observation of Resident 175's lunch tray showed a serving of green beans and red peppers. RD 1 verified findings. b. On 5/4/26 at 1228 hours, an observation and concurrent interview was conducted with the DSS during tray line observation. Resident 194's meal ticket showed a documented dislike for apple juice. An observation of Resident 194's lunch tray showed one cup of apple juice. The DSS verified findings. On 5/6/26 at 1430 hours, an interview was conducted with the Administrator, DON, Clinical Resource Nurse, and Dietary Resource. The Administrator, DON, Clinical Resource Nurse, and Dietary Resource were informed and acknowledged the above findings.

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	05/06/2026

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, document review, and facility P&P review, the facility failed to ensure the staff followed the facility's P&P on Foods Brought by Family or Visitor and failed to ensure staff were educated on safe food handling of outside food. * The facility failed to ensure food items in the residents' refrigerator were labeled with the resident name, location, and date as per the facility's P&P. * The facility failed to ensure the staff who receive the food from the residents' family and/or visitors were educated on the safe and proper food handling of outside food. These failures had the potential to cause foodborne illnesses in the medically vulnerable resident population who consumed food brought from outside sources.Findings: 1. Review of the facility's P&P titled Foods Brought by Family or Visitor (undated) showed food(s) brought to a resident by family and/or visitors must be accepted by the resident; inspected before facility storage; and stored and served in accordance with food safety professional standards. The use of outside foods is a possible intervention for residents with low intake, distinct food preferences, cultural and/or ethnic preferences. The P&P further showed all food shall be labeled with the resident name, location, and date. On 5/5/26 at 1432 hours, an observation and concurrent interview with the DSS was conducted for Residents' Refrigerators A and B. The following items were observed in Resident Refrigerator A: - One case of Black Cherry Thrifty ice cream, not labeled with name and location. - One half and half container, not labeled with name.- Two Ensure bottles not labeled with name and date.- Five diet coke bottles in a brown bag not labeled with name and date.The following item was observed in Resident Refrigerator B: - One case of McConnell's Fine Ice, dated 4/18/26 and not labeled with name. The DSS verified the above findings and stated the resident's name, date, and room number should be labeled when food items were received from families and/or visitors, as per the facility's P&P. 2. Review of CMS S&C-09-39 dated 5/29/09, showed the facility has a responsibility to help visitors understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees F. On 5/5/26 at 1432 hours, an interview with the DSS was conducted. When asked what education was provided to the families and/or visitors who bring food from outside sources, the DSS stated he instructed them that food must be as fresh as possible and when foods were brought in for the resident, the food would need to be labeled with the resident's name, date, and room number. The DSS stated he did not provide education to the families and/or visitors for proper safe food handling techniques. The DSS stated the DSD and/or the IP provided education on safe food handling. On 5/6/26 at 0953 hours, an interview with LVN 1 was conducted. LVN 1 stated the family and/or visitors who brought food from outside were educated on the residents' diet; however, denied educating on the proper safe food handling including hold temperatures for meats, preventing cross contamination, and hand hygiene. On 5/6/26 at 1142 hours, an interview was conducted with LVN 8. LVN 8 stated the facility had Resident Refrigerators A and B, for storing food brought in from outside sources. When asked whether LVN 8 educated the residents' family members and/or visitors about proper safe food handling, LVN 8 denied providing this education. On 5/6/26 at 1340 hours, an interview with the DSD was conducted. When asked, the DSD denied providing education on the proper preparation and cooking temperature of the foods and stated this education was provided by the DSS. When asked why the families and/or visitors should receive safe food handling educations, the DSD stated it was to prevent food borne illness. On 5/6/26 at 1430 hours, an interview with the Administrator, DON, Clinical Resource Nurse, and Dietary Resource was conducted. The Administrator, DON, Clinical Resource Nurse, and Dietary Resource were informed and acknowledged the above findings.

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	05/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record, facility record review, and facility P&P review, the facility failed to ensure the medical records were accurate and complete for two of 32 final sampled residents (Residents 48 and 129). * The facility failed to ensure Resident 129's Hospice Visit Communication completed forms had the resident identifier for 6/1/25 to 5/5/26. In addition, the facility failed to ensure Resident 129's Hospice Team Visit Calendar was accurately initialed. * The facility failed to ensure the elopement re-evaluation and documentation for Resident 48's exit-seeking behavior was documented in the medical records. These failures had the potential for the residents' care needs to not be met as their medical information was inaccurate and incomplete.Findings: 1. Review of the facility's P&P titled End of life Care, Hospice and /or Palliative Care dated 4/2025 showed hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into an overall individualized, interdisciplinary care plan. Collaboration with Hospice will include processes for orienting staff to facility policies and procedures which may include resident's rights, documentation and record keeping requirements. Medical record review for Resident 129 was initiated on 5/5/26. Resident 129 was admitted to the facility on [DATE]. Review of Resident 129's H&P examination dated 4/5/26, showed Resident 129 had a surrogate medical decision maker and Resident 129 had limited participation due to cognitive impairment. Review of Resident 129's Order Summary Report dated 5/5/26, showed a physician's order dated 6/23/25, to admit Resident 129 under Hospice 1. 1.a. Review of Resident 129's Hospice binder showed Hospice Visit Communication completed forms from 6/1/25 to 5/5/26, showed the disciplines visiting the resident, significant findings or new orders, and title and signature of the hospice staff visiting and the date of visit. However, under the resident's name and ID number section, it failed to show resident's name and ID number. b. Review of Resident 129's Hospice Team Visit Calendar for May 2026 showed the hospice staff initials for 5/5, 5/8, 5/12, and 5/15/26 visits. On 5/4/26 at 0904 hours, an interview and concurrent record review for Resident 129 was conducted with Case Manager 2. Case Manager 2 verified the Hospice Visit Communication completed forms from 6/1/25 to 5/5/26, had no resident identifier. Case Manager 2 also verified there were initials signed in the Hospice Team Visit Calendar for the future dates of 5/5, 5/8, 5/12, and 5/18/26. Case Manager 2 stated she did not see yet the hospice aide today. Case Manager 2 further stated the residents' name and ID number section should have been completed with Resident 129's name and the Hospice Team Visit Calendar should not be signed before resident care was performed. On 5/5/26 at 1049 hours, an interview and concurrent medical records review for Resident 129 was conducted with Hospice Nurse 1. Hospice Nurse 1 verified the missing resident's identifier on the Hospice Visit Communication completed forms dated 6/1/25 to 5/5/26 in the hospice binder. Hospice Nurse 1 stated there should have been a resident's name on the Hospice Visit Communication form prior to documenting the visits. Furthermore, Hospice Nurse 1 verified Resident 129's Hospice Team (continued on next page)

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	05/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Visit Calendar for May 2026 was pre-signed for 5/5, 5/8, 5/12, and 5/15/26. Hospice Nurse 1 verified the hospice aide did not visit yet but she signed. On 5/6/26 at 1615 hours, an interview with the Administrator and DON was conducted. The Administrator and the DON were informed of the missing resident identifiers and the pre-signed hospice calendar. The Administrator and DON acknowledged the findings. 2. Review of the facility's P&P titled Elopement/Unsafe Wandering revised 4/2025 showed the residents with capabilities of ambulation and/or mobility in wheelchair will have an Elopement/Wandering Evaluation completed to determine risks for elopement and unsafe wandering on admission and with observed behaviors of wandering or attempts to elope. Staff shall promptly report any resident who is trying to leave the premises or is suspected of being missing to the Charge nurse or Supervisor to evaluate the need for further interventions. Medical record review for Resident 48 was initiated on 5/3/26. Resident 48 was admitted to the facility on [DATE]. Review of Resident 48's H&P examination dated 3/24/26, showed Resident 48 had no capacity to understand and make decisions. Review of Resident 48's Elopement Evaluation dated 3/24/26, showed Resident 48 had no history of elopement or attempted elopement at home or at the facility, and Resident 48 did not wander or expressed the desire to go home, packed belongings to go home or stayed near an exit door. Review of Resident 48's Order Summary report dated 5/6/26, showed a physician's order dated 4/1/26, to apply the wanderguard to Resident 48's left ankle and to change every 90 days. Further review of Resident 48's medical record failed to show an elopement revaluation was conducted, or any documentation to show Resident 48 was at risk for elopement prior to the order for the application of the wanderguard. Review of Resident 48's IDT-Care Plan Review conducted with Resident 48's family member on 4/1/26, under the section special treatments, procedures and devices showed wanderguard; however, there was no other documentation to show the reason for the use of the wanderguard. On 5/4/26 at 0817 hours, Resident 48 was observed lying in bed with the wanderguard on her left ankle. On 5/6/26 at 0940 hours, an interview and concurrent medical record review for Resident 48 was conducted with RN 3. RN 3 stated if a resident was observed with exit seeking behavior, the facility would initiate a change in condition evaluation to monitor the resident for wandering or attempts to exit the facility. RN 3 stated a new elopement evaluation would be conducted and if the resident was at a high risk of elopement, the physician would be notified and an order would be obtained for the use of the wanderguard. RN 3 stated a new elopement and change in condition evaluation should have been initiated to monitor Resident 48 for elopement. On 5/6/26 at 1010 hours, an interview was conducted with LVN 6. LVN 6 stated when Resident 48 was newly admitted to the facility, she tried to pack her belongings and attempted to leave the facility. LVN 6 stated Resident 48 was easily reoriented and redirected. (continued on next page)

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	05/06/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/26 at 1049 hours, an interview and concurrent medical record review for Resident 48 was conducted with the DON. When asked about the appropriate use of the wander guard, the DON stated there should be an elopement reevaluation initiated or documentation in the nurse's progress notes to show Resident 48 had exit seeking behavior or had attempted to leave the facility. The DON further stated if the resident was at a high-risk for elopement, then the physician would be informed and an order for the use of the wander guard would be obtained. When asked to show the documentation by the licensed nurses to justify the use of the wander guard or any monitoring of Resident 48 prior to the use of the wander guard, the DON stated she could not find any documentation of Resident 48's wandering or attempts to exit the facility prior to the use of the wander guard. On 5/6/26 at 1444 hours, an interview was conducted with the Administrator, DON, and Clinical Resource Nurse. The Administrator, DON, and Nurse Consultant were informed regarding Resident 48 not having an assessment prior to the application of the wanderguard. The Administrator, DON, and Clinical Resource Nurse acknowledged the above findings.

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	05/06/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for one of three final sampled residents (Resident 52) reviewed for hospice services. * The facility failed to ensure Resident 52's medical record contained the visit notes by the Chaplain and Certified Home Health Aide (CHHA), failed to ensure the monthly hospice visitation calendar for May 2026 was available in the resident's medical record, and failed to show the day Resident 52 would be visited by the Skilled Nurse for the week of 4/26/26. These failures posed the risk of delayed communication and uncoordinated medical care between the facility and the hospice provider, which could negatively affect Residents 52's care.Findings: Review of the facility's P&P titled End of Life; Hospice and/or Palliative Care reviewed 2/2025 showed hospice services will be offered as appropriate and as ordered by the physician. These services will be integrated into the overall individualized, interdisciplinary care plan. Collaboration with Hospice will include processes for orienting staff to facility policies and procedures which may include resident's rights, documentation and record keeping requirements. Review of the facility's Hospice Services Agreement with Hospice Agency A dated 12/22/20, showed when a facility resident is admitted to the Hospice program, Hospice shall develop a plan of care (POC). Hospice shall retain responsibility for directing the implementation of each POC. The Clinal Record contains (i) the initial and subsequent assessments; (ii) the Plan of Care; (iii) identification date; (iv) consent and authorization and election forms; (v) pertinent medical history; and (vi) complete documentation of all services and events including, but not limited to, evaluations, treatments, and progress notes. Medical record review for Resident 52 was initiated on 5/3/26. Resident 52 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 52's Order Summary Report dated 5/4/26, showed a physician's order dated 3/9/26, to admit Resident 52 under Hospice A with a terminal diagnosis of end-stage Parkinson's disease. Review of Hospice A's plan of care for Resident 52 dated 3/9/26, showed the following information:- Skilled nurse to assess and evaluate Resident 52 on 3/9/26 through 3/11/26. Skilled Nursing services: one to three times per week for nine weeks; to begin during the week of 3/9/26 and end on 5/7/26.- Hospice Aide services: two times per week for one week, to begin during the week of 3/10/26. Then three times a week for eight weeks beginning the week of 3/15/26.- Chaplain to assess and evaluate on 3/9/26 through 3/14/26. Chaplain services: seven as needed visits for spiritual care. a. Review of Resident 52's hospice visitation calendar for April 2026 failed to show the scheduled visit by the Skilled nurse for the week of 4/26/26. Review of Resident 52's Hospice Visit Summary Log failed to show the documentation Resident 52 was visited by a Skilled nurse for the week of 4/26/26. b. Review of Resident 52's hospice visitation calendar for April 2026 showed the following:- the CHHA was scheduled to visit Resident 52 on 4/9/26, however, review of the CHHA sign-in form failed to show the documentation of the care provided by the hospice aide including: personal care, presence of shortness of breath and/or pain, and Resident 52's last bowel movement on 4/9/26.- the Chaplain was scheduled to visit Resident 52 on 4/29/26, however review of the Hospice Visit Summary Log failed to show the documentation Resident 52 was seen by the Chaplain. Further review of Resident 52's hospice records failed to show a hospice visitation calendar for May 2026 was available to show the scheduled weekly visits by the hospice staff members. On 5/4/26 at 1013 hours, an interview and concurrent medical record review for Resident 52 was conducted with LVN 6. LVN 6 reviewed Resident 52's hospice records and verified the above findings. On 5/5/26 at 0949 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD stated the purpose of the hospice calendars was to communicate with the facility the days the hospice staff were scheduled to see the resident in the facility. The SSD stated the calendars should be updated before the end of each month and for the next month and should be (continued on next page)

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	05/06/2026

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kept in the resident's hospice binder. The SSD further stated when the hospice staff came into the facility, they should sign the visitation log and document in the resident's progress notes. The SSD reviewed Resident 52's hospice POC and verified the plan of care showed the resident should be visited by the hospice Skilled nurse one to three times a week for nine weeks. The SSD verified there was no documentation by the hospice Skilled Nurse for the week of 4/26/26. On 5/6/26 at 1049 hours, an interview was conducted with the DON. The DON stated it was important to ensure there was coordination of care between the facility and hospice provider for a resident residing in the facility and receiving hospice services, to ensure the resident's comfort and care were being met. The DON stated the Social Services staff and Medical Records staff were responsible for ensuring the hospice staff progress notes were inside the resident's hospice binder.On 5/6/26 at 1444 hours, an interview was conducted with the Administrator, DON, and Clinical Resource Nurse. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.

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	05/06/2026

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to complete and transmit the MDS assessment timely for three of three nonsampled residents (Residents 19, 24, and 101) reviewed for resident assessments. * The facility failed to transmit Resident 19, 24, and 101's Discharge MDS assessment within the required time. This failure caused a delay in providing resident specific information for the payment and quality measure purposes to CMS.Findings: 1. Closed medical record review for Resident 24 was initiated on 5/4/26. Resident 24 was admitted to the facility on [DATE], and discharged on 12/4/25. Review of Resident 24's MDS assessments showed a Discharge MDS assessment was in-progress and was not submitted. 2. Closed medical record review for Resident 19 was initiated on 5/4/26. Resident 19 was admitted to the facility on [DATE], and discharged on 1/17/26. Review of Resident 19's MDS assessments failed to show a Discharge MDS assessment was completed and submitted. 3. Closed medical record review for Resident 101 was initiated on 5/4/26. Resident 101 was admitted to the facility on [DATE], and discharged on 1/21/26. Review of Resident 101's MDS assessments failed to show a Discharge MDS assessment was completed and submitted. On 5/4/26 at 1221 hours, an interview and closed medical record review for Residents 19, 24, and 101 was conducted with the MDS Assistant. The MDS Assistant verified the above findings. Review of a document titled Final Validation Report - CMS Submission Report dated 5/5/26, showed the following:- Resident 24's Discharge MDS assessment was accepted on 5/5/26, more than 17 weeks past the required transmission date of 1/1/26;- Resident 19's Discharge MDS assessment was accepted on 5/5/26, more than 11 weeks past the required transmission date of 2/14/26; and- Resident 101's Discharge MDS assessment was accepted on 5/5/26, more than 10 weeks past the required transmission date of 2/18/26. On 5/6/26 at 1444 hours, an interview was conducted with the Administrator, DON, and Clinical Resource Nurse. The Administrator, DON, and Clinical Resource Nurse were informed and acknowledged the above findings.