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	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Post Acute	1800 Old Tustin Avenue Santa Ana, CA 92705

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 5. Medical record review for Resident 70 was initiated on 3/17/25. Resident 70 was admitted to the facility on [DATE]. On 3/17/25 at 1600 hours, an observation and concurrent interview as conducted with Resident 70. Resident 70 was observed in his room (Room A) lying in his bed. The wall adjacent to Resident 70's bed was observed in disrepair, with scratches and chipped paint. Resident 70 stated the facility had recently repaired the wall adjacent to the entrance to his room; however, the facility had yet to repair the wall adjacent to his bed. Resident 70 stated he would like the wall adjacent to his bed repaired as he spent a lot of time inside of his room. On 3/24/25 at 1600 hours, an interview was conducted with the Administrator. The Administrator acknowledged the findings and stated the facility was in the process of repairing Resident 70's room. Based on observation and interview, the facility failed to maintain the comfortable and homelike environment for one of 33 final sampled residents (Resident 70) and four nonsampled residents (Residents 6, 40, 48, and 56) as evidenced by: * The facility failed to provide the environment with comfortable sound levels for Residents 6, 40, 48, and 56 . * The wall adjacent to Resident 70's bed was observed in disrepair, with scratches and chipped paint. These failures had the potential to result in negatively impact the residents' quality of life. Findings: Review of the facility's P&P titled Noise Control revised 2/2022 showed it is the policy of this facility to maintain a comfortable sound levels that enhance privacy when privacy is desired; as with any health care facility, the atmosphere should be calm, organized, and as quiet as possible. Employees should refrain from making loud noises or talking in a loud voice. 1. Medical record review for Resident 6 was initiated on 3/18/25. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's H&P examination dated 11/20/24, showed the resident had the capacity to make medical decisions. 2. Medical record review for Resident 40 was initiated on 3/18/25. Resident 40 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 40's H&P examination dated 3/10/25, showed the resident was alert and oriented to person, place, and time, but had no capacity to make medical decision. 3. Medical record review for Resident 48 was initiated on 3/18/25. Resident 48 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 48's H&P examination dated 5/6/24, showed the resident had the capacity to understand and make medical decisions. 4. Medical record review for Resident 56 was initiated on 3/18/25. Resident 56 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 56's H&P examination dated 10/9/24, showed the resident had the capacity to make medical decisions. On 3/18/25 at 1433 hours, during the resident council meeting, Resident 6, 40, 48, and 56 had concerns with the noise regarding slamming of the kitchen and dining room door, and the staff speaking loudly in the hallway during the shift change at night. On 3/18/25 at 1505 hours, an observation and concurrrent interview was conducted with the Administrator in regards to the noise when closing the dinning room door across from Resident 48's room. When closing the dining room door, the dining room door was observed making a loud noise. The Administrator was informed and verified the above findings. On 3/18/25 at 1520 hours, an interview was conducted with Resident 48, the resident stated the staff was slamming the dining room door at night, which was very loud, and he could not rest. On 3/18/25 at 1607 hours, an observation and concurrent interview was conduct with the Maintenance Director to check the kitchen door located across from Resident 40's room. When the dining door was closed, the dining room door made a loud noise. The Maintenance Director was informed and verified the dining room door was making a loud noise. The Maintenance Director stated, he would adjust the automatic door closer to make it close slowly, perhaps it would make less noise. On 3/18/25 at 1615 hours, an interview was conducted with Resident 40. Resident 40 stated the staff would go in and out of the kitchen, slamming the kitchen door throughout the day, which made a loud noise and she could not rest. The resident stated the facility knew about it but the issue was still there. On 3/19/25 at 0955 hours, an interview was conducted with Resident 6. Resident 6 stated the noise was very bad at the shift change. The staff got very loud and would gather in the hallway. Resident 6 stated it was very frustrating because she was trying to sleep. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/25 at 1330 hours, an interview was conducted with Residents 6, 40, and 56. The residents stated the noise from the staff was a big problem. Resident 56 stated at the 2300 hours shift change especially, the staff would gather in the hallway and socializes, and the noise would carry throughout the hallway. Residents 40 and 56 stated they had not been offered to move to another room in response to the noise complaints. On 3/24/25 at 1323 hours, an interview was conducted with the AD. The AD stated she was aware of the complaints about the noise level of the door slamming and staff talking loudly during the shift change. The AD stated the facility did the rounds to check with the residents regarding the noise level. The AD further stated it was still an ongoing issue but had improved. Review of the facility's Resident Council Meeting Minutes was initiated on 3/24/25. The minutes for January to March 2025 showed concerns with the noise level of staff talking loudly during the 2300 - 0700 hours shift change, and the kitchen and dining room doors were getting slammed at nighttime.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Potential for minimal harm Residents Affected - Some	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, and medical record review, the facility failed to ensure the comprehensive care plan was developed for one of 33 final sampled residents (Resident 123). * The facility failed to develop a comprehensive care plan to address the use of oxygen for Resident 123. This failure placed the resident at risk of not being provided the appropriate, consistent, and individualized care. Findings: Medical record review for Resident 123 was initiated on 3/17/25. Resident 123 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 123's Acute Care Hospital 1 H&P examination dated 1/25/25, showed Resident 123 was diagnosed with pneumonia. On 3/18/25 at 1143 hours, an observation was conducted of Resident 123. Resident 123 was observed lying in bed. An oxygen concentrator was observed adjacent to Resident 123's bed. The oxygen concentrator was set to administer a continuous oxygen at a rate of 2 liters per minute. The oxygen tubing and nasal cannula were observed attached to the oxygen concentrator. On 3/18/25 at 1145 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1. LVN 1 stated Resident 123 was recently readmitted to the facility from the acute care hospital. LVN 1 stated Resident 123 had received the oxygen therapy from the time she was readmitted to the facility. LVN 1 stated Resident 123 had received the continuous oxygen at a rate of 2 liters per minute throughout her shift today. LVN 1 reviewed Resident 123's physician's orders and verified Resident 123 did not have a physician's order for the oxygen therapy. On 3/19/25 at 1041 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 123's medical record and verified a care plan was not initiated for Resident 123's use of the oxygen. The DON stated a care plan for the use of the oxygen therapy should have been initiated after Resident 123 was readmitted to the facility and at the time Resident 123 first received the oxygen therapy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 care plan was revised for two of 33 final sampled residents (Residents 15 and 70). * The facility failed to ensure Resident 15's comprehensive care plan was revised to reflect a physician's order for the prescribed amount of fluid to be provided to Resident 15 with meals. The care plan showed to provide Resident 15 with 240 ml of fluid with meals; however, the physician had ordered Resident 15 to receive 360 ml of fluid with meals. * The facility failed to ensure Resident 70's comprehensive care plan was revised when there was a change of the behavior manifestation for Resident 70's use of Seroquel (antipsychotic) medication. These failures placed the residents at risk for not being provided with the appropriate, consistent, and individualized care. Findings: 1. Medical record review for Resident 15 was initiated on 3/17/25. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Order Listing Report showed a physician's order dated 2/22/24, to monitor Resident 15's fluid intake and output every shift. Resident 15's physician ordered a fluid restriction of 2000 ml per 24 hours. Resident 15's fluid intake specific to the dietary was to provide Resident 15 with a total fluids of 1080 ml per 24 hours. Resident 15 was to receive 360 ml of fluid with each meal (breakfast, lunch, and dinner). On 3/20/25 at 1537 hours, an interview and concurrent medical record review was conducted with the RD. Review of Resident 15's care plan titled Protentional for Nutritional Problem revised 3/12/25, showed a dietary intervention to provide Resident 15 with 240 ml of fluid with meals (breakfast, lunch, and dinner). The RD verified the care plan needed to be revised to show the current physician's order for the prescribed amount of fluids to be provided to Resident 15 with meals. The RD verified the physician had ordered Resident 15 to receive 360 ml of fluid with each meal (breakfast, lunch, and dinner). 2. Review of the facility's P&P titled Psychotropic Medications, Pharmacy Services revised 2/2024 showed it is the policy of this facility to ensure that the residents who have not used the psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. Psychotropic medications shall not be administered for the purpose of discipline or convenience. The Social Services (SSD) and/or nursing designee will be responsible for initiating the resident's individualized, person-centered psychosocial plan of care, based on their comprehensive initial admission assessment. Medical record for Resident 70 was conducted on 3/21/25. Resident 70 was initially admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 70's Order Summary Report dated 3/19/25, showed a physician's order dated 8/4/24, for Seroquel oral tablet (anti-psychotic medication) 25 mg 1.5 tablets by mouth at bedtime for a total of 37.5 mg for psychosis m/b seeing objects that are not there and to monitor the episodes of psychosis m/b seeing objects that are not there every shift. Review of Resident 70's Care Plan initiated on 3/26/24, showed a care plan problem was developed to address Resident 70's psychotropic medications use related to psychosis as manifested by persecutory delusions (type of paranoia) thinking people are trying to shoot him. The goal included for Resident 70 to have fewer episodes of psychosis manifested by persecutory delusions thinking people are trying to shoot him. Review of Resident 70's Care Plan initiated on 6/17/24, showed a care plan problem was developed to address Resident 70's Seroquel use for psychosis m/b persecutory delusion thinking people are trying to shoot him. Further review of Resident 70's Care Plan failed to show the care plan was revised when there was a change of the the behavior manifestation for the Seroquel medication use on 8/4/24. On 3/21/25 at 1100 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator on Resident 70's comprehensive care plans. The MDS Coordinator verified the care failed to show the current behavior manifestation of seeing objects that were not there as indicated in the physician's order for the use of the Seroquel medication. The MDS Coordinator stated the nurse who updated the behavior in the physician's order should have updated the care plan right away. On 3/21/25 at 1320 hours, an interview was conducted with the DON. The DON verified there was no revision of the care plan after a change in Resident 70's behavior manifestation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **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 12 final sampled residents (Resident 2) reviewed for ADL care received the adequate personal hygiene care. * The facility failed to provide the nail care for Resident 2 which caused self-inflicted scratches. This failure had the potential to not meet the personal care needs of the dependent residents in the facility. Findings: Review of the facility's P&P titled Activities of Daily Living revised 7/2015 showed the resident's abilities in ADL do not diminish unless circumstances on the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, groom, transfer, ambulate, toilet, eat, and use speech, language, or other functional communication systems. Grooming is defined as how the resident maintains personal hygiene, including preparatory activities, combing hair, brushing teeth, shaving, nail care, applying make-up, washing/drying face, hands and perineum. Excludes baths and showers. The interventions will be provided by the staff in accordance with the professional standards of quality and clinical practices. Nursing assistants will provide assistance with the ADL based on the resident's individualized plan of care. On 3/18/25 at 1144 hours, during the initial tour of the facility, Resident 2 was observed awake and lying in the bed. Resident 2 was observed scratching his face. Resident 2 was observed with multiple dry round black and red scabs in the forehead and bilateral cheeks. Medical record review for Resident 2 was initiated on 3/19/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Care Plan initiated on 12/19/24, showed a care plan focus problem addressing Resident 2's actual impairment to the skin integrity related to self-inflicted scratches. The interventions included to keep the fingernails short. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 had a short-term and long-term memory problems and dependent with his personal hygiene and grooming. On 3/20/25 at 0929 hours, an observation and concurrent interview was conducted with CNA 5. CNA 5 was observed repositioning Resident 2. CNA 5 stated Resident 2 needed a total care with ADL care. Resident 2 was observed scratching his face with his fingers. CNA 5 stated Resident 2 liked to scratch his face. Resident 2 was observed with long and sharp fingernails. CNA 5 stated the CNAs were responsible in cutting the resident's nails. CNA 5 verified Resident 2's fingernails were long and sharp. CNA 5 stated she could not remember when the last time she had cut Resident 2's fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/25 at 1005 hours, a follow-up observation of Resident 2 and concurrent interview was conducted with CNA 6. Resident 2 was awake and lying in the bed. Resident 2 was observed scratching his face with his fingernails. CNA 6 stated Resident 2 could not do any personal hygiene or care. CNA 6 was asked to check the fingernails of Resident 2. Resident 2 was observed still with long and sharp fingernails. CNA 6 verified the fingernails of Resident 2 were not short but long and sharp. CNA 6 stated she remembered cutting Resident 2's fingernails two weeks ago. CNA 6 stated providing the nail care to the residents was necessary for Resident 2's personal hygiene. On 3/24/25 at 1020 hours, an interview and concurrent medical record review was conducted with LVN 9. LVN 9 stated the care plan for each of the resident was individualized to meet the personal care need and should be followed. LVN 9 verified Resident 2's fingernails were long and sharp which caused skin impairment to the resident due to his self-inflicted scratches. LVN 9 stated Resident 2's fingernails should be kept short to prevent harm and infection to the resident. LVN 9 further stated Resident 2 was dependent with ADL care and the staff should assist Resident 2 with hygiene and grooming which included the trimming of the nails. On 3/24/25 at 1615 hours, an interview was conducted with the DON. The DON was notified and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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, and medical record review, the facility failed to provide the prescribed amount of fluids with meals, for one of 33 final sampled residents (Resident 15). * Resident 15's physician had ordered for Resident 15 to receive 360 ml of fluids with meals (breakfast, lunch, and dinner). However, Resident 15 only received 240 ml of fluids with meals. This failure had the potential to compromise Resident 15's hydration status and posed the risk for negative health outcomes. Findings: Medical record review for Resident 15 was initiated on 3/17/25. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's H&P examination dated 1/14/25, showed Resident 15 had a diagnosis of End-Stage Renal Disease and required hemodialysis three times per week. Review of Resident 15's Order Listing Report showed a physician's order dated 2/22/24, to monitor Resident 15's fluid intake and output every shift. Resident 15's physician ordered a fluid restriction of 2000 ml per 24 hours. Resident 15's fluid intake specific to the dietary was to provide Resident 15 with a total fluids of 1080 ml per 24 hours. Resident 15 was to receive 360 ml with each meal (breakfast, lunch, and dinner). On 3/20/25 at 1355 hours, an observation and concurrent interview was conducted with Resident 15. Resident 15 was observed lying in bed. R esident 15 was asked to describe the amount of fluid she was provided with breakfast, lunch, and dinner. Resident 15 stated she only received a carton of Nepro (240 ml, supplement) with breakfast, lunch, and dinner. Resident 15 was asked to describe what fluids she liked to consume. Resident 15 stated she enjoyed several different types of fluids, which included water, juice (apple and cranberry), and hot chocolate. On 3/20/25 at 1557 hours, an interview and concurrent medical record review was conducted with the RD. The RD was asked the amount of the fluid from the kitchen provided to Resident 15 with her meals (breakfast, lunch, and dinner). The RD then reviewed Resident 15's kitchen's Diet Order dated 3/20/25. The RD stated Resident 15's Diet Order showed Resident 15 had a standing order for Nepro 8 fluid ounces (240 ml) to be provided to Resident 15 with meals. The RD was then asked to review the physician's order specific to the amount of fluid Resident 15 was to receive with meals. The RD verified Resident 15's physician had ordered a 2000 ml per 24 hour fluid restriction. The RD verified Resident 15's physician had ordered for the dietary to provide Resident 15 with 360 ml of fluids with each meal (breakfast, lunch, and dinner). The RD verified the dietary department was only providing Resident 15 with 240 ml of fluid with meals, and should have provided Resident 15 with the 360 ml of fluid with meals, in accordance with the physician's order. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RD stated Resident 15 having only received 240 ml of fluids with meals was consistent with a 1000 ml per 24 hour fluid restriction. However, Resident 15 should have been provided with 360 ml of fluids with meals, in accordance with the physician's order of 2000 ml per 24 hour fluid restriction. The RD reviewed Resident 15's medical record and verified there was no documentation Resident 15 had refused to receive the physician's ordered amount of fluids (360 ml) to be provided with meals. The RD also verified there was no documentation Resident 15's physician was notified Resident 15 had not received the ordered amount of fluids to be provided with meals. The RD was asked how long Resident 15 had not received the ordered amount of fluids (360 ml) with meals, to which the RD replied from at least 3/12/25. The RD stated she would speak to Resident 15 regarding fluid preferences and then provide Resident 15 with an additional 120 ml of fluids with meals, in accordance with the physician's order. On 3/20/25 at 1506 hours, an interview was conducted with Resident 15 and the RD. Resident 15 stated she wanted 360 ml of fluid with her meals, in accordance with her physician's order. Resident 15 stated she liked several types of fluids which included, juice (apple and cranberry), water, milk, and chocolate milk. The RD stated she would start to provide Resident 15 with 360 ml of fluids with her meals, in accordance with Resident 15's fluid preferences and the physician's order. Cross reference to F657, example #1.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for five of six final sampled residents (Residents 24, 125, 139, 145, and 816) reviewed for the IV care. * The facility failed to ensure the dressing change was completed weekly, the arm circumference and external catheter length of the PICC line were measured, and the care plan was developed timely for Resident 24's PICC line use . * The facility failed to ensure the dressing change was completed weekly, the arm circumference and external catheter length for midline were measured, and the care plan was developed for Resident 125's midline IV catheter use. * The facility failed to obtain a physician's order for the care and maintenance of the IV line and developed a plan of care for Resident 139's IV use. * The facility failed to ensure the arm circumference and external catheter length were measured on admission and during the PICC line dressing change for Resident 816's PICC line use. * The facility failed to ensure the peripheral IV site was label with date, time, and initials when the IV was inserted, the plan of care was developed for use of IV site, and a physician's order was obtained for the care and maintenance of the peripheral IV site as per the facility's P&P for Resident 145. These failures had the potential to delay the identification of catheter-related complications for the residents. Findings: Review of the facility's P&P titled Intravenous (IV) Administration of Drugs via Central Venous Catheter (CVC) or Peripherally Inserted Central Catheters (PICC) (undated) showed the central, PICC, and midline catheter dressing shall be changed every seven days from date of insertion or as ordered per they physician. Review of the facility's P&P titled Insertion of Peripheral I.V. Device (undated) showed to label the dressing with the date and time the site was inserted, the gauge and length of the catheter inserted, and the initials of the inserting nurse. 1. Medical Record Review for Resident 24 was initiated on 3/17/25. Resident 24 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 24's Order Summary Report dated 3/18/25, showed a physician order dated 3/12/25, to measure the arm circumference in inches on admission and every seven days during the dressing changes every day shift, and measure the external catheter length in cm from end to the hub to the insertion site into skin. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 24's Care Pan dated 3/18/25, showed a care plan problem addressing Resident 24 was on IV medications (Vancomycin or Ertapenem). The intervention included to check the dressing at the site daily. Review of Resident 24's IV MAR for March 2025 showed the following: - the dressing and securement device to change on 3/9/25, using the sterile techniques one time a day - on 3/13 and 3/20/25, showed an entry of N/A for the staff to measure the arm circumference in inches every seven days during dressing changes. On 3/19/25 at 1128 hours, an observation and concurrent interview was conducted with RN 2. Resident 24's PICC line dressing was observed to be loose, was dated 3/4/25, and required changing. RN 2 stated the dressing was dated 3/4. RN 2 added, We do measure it. We take a measurement of the length from the arm hub and arm circumference measurements during the dressing changes. On 3/20/25 at 1042 hours, an interview and concurrent record review was conducted with the MDS Coordinator. The MDS Coordinator stated the PICC line care plan was initiated on 3/18/25. The MDS Coordinator further stated the timeline was to initiate a care plan for the PICC line within 24 hours after 3/12/25. The MDS Coordinator acknowledged the care plan was initiated late and dressing change was not done weekly since Resident 24's PICC line dressing was dated 3/4/25. On 3/20/25 at 1509 hours, an interview and concurrent record review was conducted with the MDS Coordinator. The MDS Coordinator was asked for the measurements of the arm circumference and external catheter length of the PICC line. The MDS Coordinator was unable to provide the documentation. The MDS Coordinator stated additional education might be necessary to ensure the proper documentation. The documentation for the dressing change did not allow progression without entering a measurement, and the nurses had been bypassing this requirement by entering N/A. The MDS Coordinator verified the findings. 2. Medical record review for Resident 125 was initiated on 3/17/25. Resident 125 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 125's IV MAR for March 2025 showed the following: - on 3/2, 3/9, and 3/16/25, the resident's dressing and securement device was changed using sterile techniques. - on 3/8/25, showed documentation of N/A and on 3/15/25, it was blank for the order to measure the arm circumference in inches during dressing changes On 3/17/25 at 0926 hours, an observation and concurrent interview was conducted with LVN 2. Resident 125's midline IV catheter was observed in the right upper arm and was dated 3/2/25. LVN 2 verified Resident 125's midline IV catheter dressing was dated 3/2/25. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25 at 1042 hours, an interview and concurrent record review was conducted with the MDS Coordinator. The MDS Coordinator was asked when the arm circumference and external length of the midline IV catheter should be measured. The MDS Coordinator stated upon admission, they checked the dressing, measured the arm circumference, and measured the length of the midline IV catheter from the dressing to the hub. They also requested a confirmation X-ray to verify the placement and if necessary, the dressing was changed at that time. The MDS Coordinator stated the policy required the dressing changes every seven days, during which the measurements were also taken. The timeline mandated initiating a care plan for the midline IV catheter within 24 hours. The MDS Coordinator further stated if the midline IV catheter dressing was dated 3/2/25, it would indicate the dressing change was not performed weekly. Additionally, the MDS Coordinator stated the care plan was updated whenever there was a change of condition (COC), as well as upon admission and quarterly for the midline IV catheter. The MDS Coordinator further stated whoever admitted the resident was responsible for initiating a care plan for the midline IV catheter. The MDS Coordinator acknowledged there was no care plan for Resident 125's midline IV catheter. The policy for the dressing changes was the same for both the midline IV catheter and PICC lines. The RN administering the medication was responsible for checking the dressing date and changing it every seven days, or as needed. The IV monitoring was recorded on the IV MAR, which only the RN could access. The MDS Coordinator stated timely dressing changes were critical to maintaining the IV site cleanliness and preventing infection. A soiled IV dressing can loosen and increase the risk of infection, particularly with the central line, which carries a higher risk of infection. The MDS Coordinator verified the above findings. 4. On 3/18/25 at 0940 hours, during the initial tour of the facility, Resident 816 was observed awake and lying in the bed. Resident 816 was observed with a PICC line to the right upper arm. Resident 816 stated he was getting antibiotics for his bone infection. Resident 816's PICC line dressing was observed dated 3/17/25. Medical record review for Resident 816 was initiated on 3/18/25. Resident 816 was admitted to the facility on [DATE]. Review of Resident 816's Order Summary Report showed the following physician's orders dated 3/11/25, to measure the arm circumference in inches on admission, measure the arm circumference in inches every seven days during the dressing changes, and measure the external catheter length in centimeters from end to hub to the insertion site into skin. Review of Resident 816's MDS assessment dated [DATE], showed Resident 816 was cognitively intact. Review of Resident 816's IV MAR for March 2025 showed no documentation of the PICC line dressing changed on 3/17/25, measurement of the arm circumference, and length of the PICC line external catheter. Further review of Resident 816's medical record failed to show any documentation of the measurement of the arm circumference on admission and during the PICC line dressing change and the measurement of the external catheter length of the PICC line. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/25 at 1415 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the PICC line dressing of Resident 816 was dated 3/17/25. RN 1 stated she worked that day but was not the one who did the PICC line dressing change for Resident 816. RN 1 stated it was necessary to assess and measure the arm circumference where the PICC line was inserted to determine if the PICC line site had any changes that could indicate signs of infection and as a basis of comparison for the next assessment to be done by the nurse. RN 1 stated the length of the external catheter of the PICC line should also be measured to ensure the proper placement of the PICC line and to prevent complications. RN 1 further stated the central line dressing kit the facility had been using also included the disposable paper measuring tape to be used in measuring the arm circumference and the length of the external catheter. RN 1 verified there was no documentation in Resident 816's medical record to show the arm circumference was measured on admission and during the dressing change of the PICC line, and no documentation the external catheter length of the PICC line was measured as well. On 3/24/25 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 5. On 3/17/25 at 0940 hours, Resident 145 was observed with a peripheral IV line on the right wrist with a single lumen port without label of the date, time and initials. On 3/17/25 at 1025 hours, an observation and concurrent interview for Resident 145 was conducted with the DON. The DON was informed and verified there was no date, time, and initial label on Resident 145's IV site. The DON further stated it was important to label the IV site to know when it was inserted and change the IV site appropriately. Medical record review for Resident 145 was initiated on 3/18/25. Resident 145 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 145's H&P examination dated 2/19/25, showed the resident was alert and oriented to name, place, location, and time. Review of Resident 145's MDS dated [DATE], showed the resident had a BIMS score of 15, indicating the resident had intact cognition. Review of Resident 145's Order Summary Report dated 3/18/25, showed the following physician's order: - dated 3/15/25, to administer Ertapenem Sodium Solution (antibiotic) 1 gm intravenously one time a day for infection prevention status post procedure for 7 days until finished, and - dated 3/17/25, for maintenance, to flush with 10 ml of NS at least every 12 hours and PRN. Review of Resident 145's Progress Notes showed the nursing note completed by LVN 7 dated 3/14/25, showed the resident returned from his appointment with an IV line to the right hand, and the dressing was clean, dry, and intact. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/25 at 1026 hours, an interview and concurrent record review for Resident 145 was conducted with the DON. The DON was informed and verified there was no physician's order for the care and maintenance of the peripheral IV line, and no plan of care was developed for the use of the IV site on 3/14/25. The DON stated the physician's order for the IV maintenance and plan of care should have been initiated on 3/14/25, when Resident 145 had the peripheral IV line. 3. Review of the facility's P&P titled Intermittent Infusion Therapy via Peripheral Line (undated) showed that when the infusion is complete, the tubing set should be disconnected from the needleless injection cap, and the distal hub of the tubing set should be covered with a sterile protective cap. The injection cap, extension set, and access device should be flushed with 3 to 5 ml of normal saline. Documentation should include the licensed nurse's notes in the resident 's medical record, detailing the assessment of the access device while it was being flushed, any other infusion-related complications encountered, or any adverse reactions observed in the resident. Medical record review for Resident 139 was initiated on 3/17/25. Resident 139 was admitted to the facility on [DATE]. On 3/17/25 at 0720 and 0830 hours, Resident 139 was observed in bed with an IV line on the right hand. The transparent dressing on the IV site was dated 3/16/25. Review of the IV MAR for March 2025 showed the physician's order for one liter of sodium chloride solution 0. 9% intravenously at a rate of 200 ml per hour as hydration therapy, which was administered on 3/16/25. On 3/18/25 at 1000 hours, an observation, interview and concurrent record review was conducted with RN 2. RN 2 verified Resident 139's IV line on the right hand and stated he was not aware of the IV line, and the IV line was used for Resident 139's hydration. RN 2 stated a physician's order for the IV maintenance should have been obtained when the IV hydration was administered. When asked whether any maintenance care or assessment of the IV site had been provided and a care plan had been developed to address Resident 139's IV site, RN 2 was unable to provide for any documentation for the maintenance, assessment, and care plan for Resident 139's IV site. RN 2 verified the findings. On 3/20/25 at 1500 hours, an interview and concurrent record review was conducted with RN 1. RN 1 stated for the maintenance care of peripheral IV line not in use, the nurse should assess the site every shift for complications and flush the IV line with 10 ml of normal saline at least every 12 hours and as needed. The IV catheter should remain in place as long as the site was free of complications, with a maximum duration of seven days, after which the IV should be discontinued. RN 1 further stated the nurse who initiated the IV line must obtain an order from the physician for the maintenance care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On 3/18/25 at 0852 hours, during the initial tour of the facility, Resident 815 was observed awake and sitting on the bed. Resident 815 was observed holding the oxygen tubing. The oxygen tubing was observed without a date label. Resident 815's oxygen concentrator setting was at a rate of 2 liters per minute. Medical record review for Resident 815 was initiated on 3/18/25. Resident 815 was admitted to the facility on [DATE]. Review of Resident 815's H&P examination dated 3/14/25, showed Resident 815 could make needs known but could not make medical decisions. Review of Resident 815's Order Summary Report showed a physician's order dated 3/18/25, for oxygen via nasal cannula at 2 liters per minute if the oxygen saturation level less than 90% as needed. Review of Resident 815's Weights and Vitals Summary showed Resident 815's oxygen saturation level in room air was 98% on 3/18/25. On 3/18/25 at 0932 hours, a follow-up observation of Resident 815 was conducted. Resident 815 was observed sitting at the edge of the bed. The oxygen tubing was observed on the bed and had no bag and label. The oxygen concentrator was observed to be on. On 3/18/25 at 1019 hours, an observation of Resident 815 and concurrent interview was conducted with LVN 1. The oxygen tubing was observed rolled and tucked in the oxygen concentrator's handle. LVN 1 stated the oxygen tubing should be labeled with the date when it was first used or changed and should be kept inside a plastic bag when not in use to avoid the buildup of residue in the tubing and for infection control measure. LVN 1 further stated the oxygen tubing was being changed every 72 hours. LVN 1 verified the oxygen tubing for Resident 815 was not labeled with the date when it was provided or changed and was not kept in a sanitary condition. LVN 1 stated she would dispose the oxygen tubing and replace with a new one. On 3/19/25 at 1418 hours, an interview was conducted with the IP. The IP stated the oxygen tubing was changed weekly. The IP stated the oxygen tubing should be labeled with the resident's name and the date when it was changed. The IP stated the oxygen tubing had to be placed in a plastic bag/storage when not in use. The IP stated if the oxygen tubing was on the floor or had touched any of the resident's surroundings, it had to be replaced because it had been contaminated and if it was used again, it could cause respiratory infection or illness. 3. Medical record review for Resident 695 was initiated on 3/18/25. Resident 695 was admitted to the facility on [DATE]. Review of Resident 695's H&P examination dated 3/11/25, showed Resident 695 was alert and oriented to self and location. Review of Resident 695's Order Summary Report dated 3/18/25, showed a physician's order dated 3/12/25, for oxygen to titrate at a rate of 2-5 liters per minute via nasal cannula continuously to maintain the oxygen saturation level at 92% every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 1136 hours, an observation and concurrent interview for Resident 695 was conducted with LVN 2 at Resident 695's bedside. LVN 2 verified there was no date on Resident 695's nasal cannula and humidifier bottle. LVN 2 stated the nasal cannula and humidifier bottle should be labeled with the date for the staff to know when the nasal cannula and humidifier bottle should be changed. On 3/18/25 at 1425 hours, an interview was conducted with the DON. The DON was informed and verify the above findings. The DON stated it was important to put the date on the nasal cannula and humidifier bottle so they would know when to change them to prevent infection. Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the respiratory services in a safe and sanitary manner in accordance with the facility's P&P for three of three residents (final sampled resident, Residents 123 and 614; and nonsampled resident, Resident 815) reviewed for the respiratory care. * Resident 123 received oxygen therapy without a physician's order and Resident 123's oxygen tubing and nasal cannula were not maintained in a sanitary manner. * The facility failed to ensure the oxygen tubing was labeled and stored in sanitary manner for Resident 815. * The facility failed to ensure Resident 614's oxygen tubing and humidifier bottle were labeled with the date when they were last changed, in accordance with the facility's P&P. These failures had the potential for negative health outcomes for a highly vulnerable resident population related to poor infection control practices and the administration of the oxygen therapy without a physician's order. Findings: Review of the facility's P&P titled Oxygen, Use of revised 5/2021 showed the tubings, humidifiers and other disposables used for the oxygen administration will be dated in an identifiable fashion. 1. Medical record review for Resident 123 was initiated on 3/17/25. Resident 123 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 123's Acute Care Hospital 1 H&P examination dated 1/25/25, showed Resident 123 was diagnosed with pneumonia. Review of Resident 123's Care Plan titled Pneumonia initiated on 2/7/25, showed Resident 123's pneumonia would resolve without complications. On 3/18/25 at 1143 hours, an observation was conducted of Resident 123. Resident 123 was observed lying in bed. An oxygen concentrator was observed adjacent to Resident 123's bed. The oxygen concentrator was set to administer a continuous oxygen at a rate of 2 liters per minute. The oxygen tubing and nasal cannula were observed attached to the oxygen concentrator. The oxygen tubing and nasal cannula were observed lying on the floor adjacent to Resident 123's bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 1145 hours, an observation, interview, and concurrent medical record review was conducted with LVN 1. LVN 1 stated Resident 123 was recently readmitted to the facility from the acute care hospital. LVN 1 stated Resident 123 had received an oxygen therapy from the time she was readmitted to the facility. LVN 1 stated Resident 123 had received continuous oxygen at a rate of 2 liters per minute throughout her shift today. LVN 1 was asked to review Resident 123's current physician orders specific to the oxygen therapy. LVN 1 then reviewed Resident 123's physician's orders and verified Resident 123 did not have a physician's order for the oxygen therapy. LVN 1 also verified Resident 123's oxygen tubing and nasal cannula were lying on the floor and needed to be maintained in a sanitary condition. Cross reference to F656.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and medical record review, the facility failed to provide the necessary care and services to attain and maintain the highest practicable physical, well-being for two of 33 final sampled residents (Residents 162 and 816). * Resident 162 had scheduled dialysis treatments three times per week at a dialysis center. On the days Resident 162 was scheduled at dialysis, the resident's blood pressure medications were not held as ordered by the physician. This failure posed the risk for Resident 162 not being provided with appropriate care and treatment and possible medical complications. * The facility failed to ensure Resident 816's dialysis access site was assessed and monitored appropriately and consistently. This failure had the potential for Resident 816 not being provided with the appropriate care and medical complications related to the resident's dialysis access site. Findings: 1. Medical Record Review for Resident 162 was initiated on 3/18/25. Resident 162 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Physician's Orders for 12/2024 showed the following physician's orders: - dated 12/19/24, not to administer antihypertensive medications on dialysis days (Monday, Wednesday, and Friday during the day shift). - dated 12/26/24, to discontinue the directive to withhold antihypertensive medications on dialysis days (Monday, Wednesday, and Friday during the day shift). - dated 12/29/24, to administer one tablet by mouth once daily for hypertension and to hold the dose if systolic blood pressure (SBP) less than 110 mmHg or on dialysis days. Review of Progress Notes for 12/24 showed the following: - dated 12/22/24 at 1257 hours, the resident refused a scheduled dialysis appointment. - dated 12/24/24, the resident was scheduled to be picked up around 0900 hours for dialysis. - dated 12/29/24 at 0856 hours, the resident left for the dialysis treatment in a wheelchair. - dated 12/31/24 at 0900 hours, the resident left for dialysis treatment in a wheelchair via transport. Review of the MAR for 12/24 showed the following: - The Benazepril hydrochloride (antihypertensive) oral tablet (10 mg) medication was administered on 12/22, 12/24, 12/29, and 12/31/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 1500 hours, an interview and concurrent medical record review were conducted with the DON. The DON was asked whether the blood pressure medication Benazepril should have been held as ordered by the physician on the dialysis days. The DON acknowledged that on 12/22, 12/24, 12/29, and 12/31/24, the resident went out for the dialysis, and the blood pressure medication should have been held as per the physician's order. The DON verified the findings. 2. Review of the facility's P&P titled Renal Dialysis, Care of Resident, Hemodialysis Access Site, Plan of Care revised 5/2019 showed: - the AV fistula and AV graft sites are checked for condition and bruit and thrill every shift; - the physician(s) are notified immediately of any apparent complications; - to inspect hemodialysis access site for redness, swelling and bleeding once per shift; and - to routinely check the AV fistula and/or AV graft site for bruit and thrill once per shift. If bruit changes in regularity and depth, notify the physician immediately. On 3/18/25 at 0940 hours, during the initial tour of the facility, Resident 816 was observed awake and lying in the bed. Resident 816 stated he had dialysis every Monday, Wednesday, and Friday (MWF). Resident 816 was observed with an AV shunt to the left upper arm. Medical record review for Resident 816 was initiated on 3/18/25. Resident 816 was admitted to the facility on [DATE]. Review of Resident 816's MDS assessment dated [DATE], showed Resident 816 was cognitively intact. Review of Resident 816's Order Summary Report showed the following physician's orders: - dated 3/10/25, to assess shunt site for bruit and thrill every shift. Document (+) or (-). Call the MD for absence; - dated 3/10/25, for AV shunt old site (left upper arm), to monitor for redness, bleeding, skin breakdown, and edema; and - dated 3/18/25, for the dialysis center schedule time MWF at 0400 hours. Review of Resident 816's Care Plan initiated on 3/12/25, showed a care plan focus problem addressing Resident 816 being on hemodialysis related to ESRD (end stage renal disease). The interventions included to monitor the AV shunt old site (left upper arm) for redness, bleeding, skin breakdown and edema, to assess shunt site for bruit and thrill every shift and document (+) or (-), and to call MD for absence. Review of Resident 816's MAR for March 2025 showed the licensed staff documented Resident 816's AV shunt as follows: - (-) or negative for thrill and bruit on 3/11 to 3/14 for the PM shift; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- (-) or negative for thrill and bruit on 3/11, 3/12, 3/16, and 3/19, and (X) on 3/13 for the noc shift; - (Y) or yes for the presence of redness, bleeding, skin breakdown and edema in the AV shunt old site on 3/12 and 3/14/25 for the PM shift; and 3/11, 3/12, and 3/14/25 for the noc shift. Further review of Resident 816's medical record failed to show the physician was notified when the AV shunt was assessed with absence or negative for thrill and bruit, and for the presence of redness, bleeding, skin breakdown an edema. On 3/20/25 at 1120 hours, an interview and concurrent medical record review was conducted with LVN 10. LVN 10 verified Resident 816 had the left upper arm AV shunt. When asked about the assessment of the dialysis access site per shift as documented in the MAR, LVN 10 stated the positive sign + meant there was present, while the negative sign - and X meant there was none, or absent referring to the bruit and thrill noted from the resident's access site. LVN 10 stated the Y meant there was presence of redness, bleeding, skin breakdown or edema and those could be a sign of infection. LVN 10 verified Resident 816's AV shunt was assessed without thrill and bruit, and with presence of redness, bleeding, skin breakdown and edema as recorded in the MAR but there was no documentation of the physician being notified. LVN 10 stated the licensed staff should have notified the physician because it was a change in condition if the AV shunt was assessed without thrill and bruit and with the presence of redness, bleeding, skin breakdown and edema. On 3/20/25 at 1415 hours, an interview was conducted with RN 1. RN 1 stated it was necessary to assess the dialysis access site properly to determine if there was change in condition. RN 1 stated the physician was needed to be notified as soon as possible if there was absence of bruit and thrill, and for the presence of redness, edema, bleeding and skin breakdown to implement the proper interventions per the physician's order. On 3/24/25 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility record review, and facility P&P review, the facility failed to ensure proper accounting and safeguarding of the controlled medications to prevent loss, diversion, or accidental exposure; and failed to ensure proper administration of eye drop medication for one nonsampled resident (Resident 71). * The facility failed to ensure the incoming and outgoing licensed nurses assigned to Medication Carts 2 and Cart 3 consistently signed the narcotic binder titled Controlled Substance Log. This failure posed the risk for loss or diversion of controlled medications in the facility. * The facility failed to ensure the eye drop medication was administered properly to Resident 71. This failure posed the risk of not receiving the eye drop as ordered to maintain the resident's well being. Findings: Review of the facility's P&P titled Pharmacy Services, Controlled Medications revised 12/2019 showed it is the policy of this facility to provide separately locked, permanently affixed compartments for storage of controlled drugs listed in the Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. The Procedures section showed at each shift change, a physical inventory of all the controlled medications is conducted by two licensed nurses and is documented on every shift Controlled drug count audit record. Current controlled medication accountability records and every shift Controlled drug count audit are kept. a. Review of Medication Cart 2's Controlled Substance Log showed multiple missing nurses' signatures on the following: - dated 11/16/24, for 3-11 shift, outgoing nurse - dated 11/20/24, for 11-7 shift,outgoing nurse - dated 1/31/25, for 7-3 shift, outgoing nurse - dated 3/15/25, for 11-7 shift, incoming nurse On 3/18/25 at 1105 hours, an interview and concurrent facility document review was conducted with LVN 3. LVN 3 verified there were multiple licensed nurses' signatures missing in the Controlled Substance Log. LVN 3 stated the Controlled Substance Log should be signed or initialed by the nurses to account for the narcotic medications to avoid possible drug diversion. b. Review of Medication Cart 3's Controlled Substance Log showed multiple missing nurses' signatures on the following: (continued on next page)

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	555765	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Post Acute	1800 Old Tustin Avenue Santa Ana, CA 92705

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 1/12/25, for 3-11 shift, incoming nurse - dated 1/21/25, for 11-7 shift, outgoing nurse - dated 1/20/25, for 7-3 shift, outgoing nurse On 3/18/25 at 1135 hours, an interview and concurrent facility document review was conducted with LVN 4. LVN 4 verified multiple licensed nurses' signatures were missing in the Controlled Substance Log. On 3/21/25 at 1145 hours, an interview and concurrent facility document review of the Controlled Substance Logs for Medication Carts 2 and 3 was conducted with the DON. The DON verified the above findings. The DON stated the nurses should have signed the controlled log so that the medication were accounted, and the nurses knew the medications were complete when they come to work. 2. Review of the facility's P&P titled IIB5: Eye Drop Administration revised 10/2019 showed to administer ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner. While the eye is closed, use one finger to compress the tear duct in the inner corner of the eye for one to two minutes. This reduces systemic absorption of the medication. Alternatively, the resident may keep his/her eyes closed for approximately three minutes. On 3/19/25 at 0908 hours, a medication administration observation was conducted with LVN 9. LVN 9 administered the brimonidine tartrate ophthalmic solution (an eye drop medication for glaucoma), one drop in both eyes of Resident 71. After instilling the eye drop solution to Resident 71's eyes, LVN 9 instructed the resident to close his eyes for one minute. However, Resident 9 opened his eyes immediately and started talking to LVN 9 informing LVN 9 that he wanted some sugar. LVN 9 left Resident 71's room to get the requested sugar. Resident 71 was observed opening and closing his eyes intermittently and wiped his eyes. Medical record review of Resident 71 was initiated on 3/19/25. Resident 71 was readmitted to the facility on [DATE]. Review of Resident 71's MDS assessment dated [DATE], showed Resident 71 had moderate cognitive impairment. Review of Resident 71's Order Summary Report for March 2024 showed a physician's order dated 1/17/25, to instill brimonidine tartrate ophthalmic solution 0.2% one drop in both eyes two times a day for mild open-angle glaucoma. On 3/19/25 at 1007 hours, an interview was conducted with LVN 9. LVN 9 stated she should have compressed the inner corner of the eyes of Resident 71 and stayed with the resident to make sure the eyes were closed for one full minute and the eye drop medication could have been absorbed fully. LVN 9 stated she would call Resident 71's physician and ask if another dose of the eye drop medication would be needed for the morning since she did not observe Resident 71's eyes were closed for one full minute. On 3/24/25 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure proper storage, labeling, and disposal of the medications. * One vial of Lidocaine (anasthetic, numbing medication) 1% removed from Medication room [ROOM NUMBER]'s IV e-kit was not documented in the Emergency Kit Usage Log. This failure has the potential for the medication in the emergency kit to be lost and/or not be replaced. * The facility failed to ensure the expired Santyl ointments were removed from Treatment Cart 2. This failure had to potential for using of the expired medications. Findings: 1. Review of the facility's P&P titled Pharmacy Services, Emergency Drug Supply revised 11/2007 showed it is the policy of this facility to establish a method of providing residents with emergency medications prior to the receipt of filled prescriptions for that medication. A physician's order is required to justify the use of any drug from the emergency drug supply. The Procedures section showed the following: 1. Check the medication on the outside or inside of the emergency box/ kit for the physician-ordered drug. 2. Break the seal lock on the box. 3. Remove medication to administer following dose ordered and fill out the information on the Emergency Kit Usage Log (date, resident, medication, and quantity). Place the log sheet in the emergency kit box and secure the box with a replacement lock. Repeat this procedure for each dose until the complete prescription is received from the Pharmacy. Keep a facility copy of the Emergency Kit Usage Log. On 3/18/25 at 0841 hours, an observation of Medication room [ROOM NUMBER]'s IV e-kit, facility document review, and concurrent interview was conducted with the IP. The IP stated if the e-kit box was sealed with red lock, it meant the kit was already opened and medication had been taken from the box. Review of the facility's IV e-kit inventory list showed the kit included one vial of Lidocaine. The IV e-kit was observed and one vial of Lidocaine was missing. Review of the Emergency Kit Usage Log failed to show documented evidence on the date, name of the resident, and quantity of Lidocaine taken. The IP verified the vial of Lidocaine was removed from the e-kit and there was no documentation showing when it was taken from the IV e-kit, to who it was given to and on what date. On 3/20/25 at 1615 hours, an interview was conducted with the IP and DON. The IP verified the findings. The DON stated the nurse who took the medication from the e-kit should have documented it on the usage log. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility's P&P titled IC9: Medication Labels revised 9/2019 showed the medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels. Using professional judgment, the pharmacist may label medications with different expiration dates that the manufacturers' labeling on the original container. The pharmacy label supersedes other information on the medication container and all other labeling recommendations. On 3/18/25 at 1408 hours, an inspection of Treatment Cart 2 and concurrent interview was conducted with LVN 8. The following findings were verified with LVN 8: - Santyl collagenase ointment (a topical enzyme medication used for wound management) 30 grams 250 units/gram with an expiration date of 1/31/25, was written on a yellow label with initial; and - Santyl collagenase ointment 30 grams 250 units/gram with an expiration date of 2/8/25, was written on a yellow label with initial. LVN 8 further stated they should follow the date written if there was a label with a specific expiration date. LVN 8 stated any expired medications or medical supplies should be disposed. On 3/24/25 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the food preference was honored for one of 33 final sampled residents (Resident 34). This failure had the potential for poor meal intake and negatively impact Resident 34's psychosocial well-being. Findings: Medical Record Review of Resident 34 was initiated on 3/17/25. Resident 34 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 34's care plan dated 2/24/25, showed a care plan for nutrition related to hyperlipidemia, asthma, anxiety, and risk for weight loss or gain. The interventions included honoring the resident's rights to make personal dietary choices and providing dietary education as needed. Review of Resident 34's Nutrition Evaluation and RD Nutrition Review dated 3/1/25, showed Resident 34 disliked the bacon, pork, mushrooms, spinach, olives, cabbage, and shredded carrots. Review of Resident 34's Diet Card dated 3/20/25, showed for breakfast, lunch, and dinner, Resident 34 disliked the bacon, pork, mushrooms, spinach, olives, cabbage, and shredded carrots. On 3/17/25 at 0730 hours, an observation and concurrent interview was conducted with Resident 34. Resident 34 was observed sitting upright in bed. Resident 34 expressed feeling upset because despite informing the staff of her food dislikes, some of these items were still being served to her. On 3/17/25 at 1140 hours, Resident 34 was observed sitting upright in bed. Resident 34 was served cabbage and carrots for lunch despite her diet card clearly noting her dislikes for the cabbage and shredded carrots. On 3/17/25 at 1225 hours, an observation of Resident 34 and concurrent interview was conducted with CNA 3. Resident 34 was observed not eating her lunch and requesting a turkey sandwich from CNA 3. CNA 3 was asked about the cabbage and shredded carrots on the lunch tray. CNA 3 acknowledged Resident 34 disliked those items. CNA 3 verified the lunch tray should not been served with cabbage and chopped carrots. CNA 3 verified the findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the special eating equipment was provided during the mealtime for one of 33 final sampled residents (Resident 27). This failure posed the risk for Resident 27 not maintaining or improving his independence in self-feeding skills when consuming meals and snacks. Findings: Medical record review of Resident 27 was initiated on 3/17/25. Resident 27 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 27's Nutrition Evaluation and RD Nutritionist Review dated 10/8/24, showed the resident was to have a magic cup for lunch and dinner. Review of Resident 27's Order Summary Report dated 3/20/25, showed a physician order dated 2/7/25, may benefit from a sippy cup to promote independence with self-feeding. Review of Resident 27's Diet Card dated 3/20/25, showed for breakfast, lunch, and dinner to include the adaptive equipment: sippy cup. On 3/17/25 at 1220 hours, an observation of Resident 27 and concurrent interview was conducted with CNA 4. Resident 27 finished one cup of nectar milk in a regular cup and drank 3/4 of nectar cranberry juice from a regular cup. CNA 4 verified the resident did not have a sippy cup and the kitchen should have provided it. CNA 4 further stated LVN 8 checked the food tray. On 3/17/25 at 1230 hours, an interview and concurrent medical record review was conducted with LVN 8. LVN 8 stated Resident 27 should have been provided with a sippy cup and verified the findings.

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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 the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particle or residue. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the chest freezer had a thermometer to monitor the temperature of the freezer. * The facility failed to ensure the cold beverage were maintained within the acceptable temperature range. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the foods prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 3/17/25, showed 151 of 160 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Hoods, Filters, and Vents (undated) showed the hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 3/17/25 at 0812 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the RD and Assistant DSS. The kitchen hood over the stove had black, dirt residue. The RD and Assistant DSS acknowledged the findings. The RD stated the dietary staff cleaned the hood once a month and the Assistant DSS stated it should have been cleaned for infection control purposes and it was a fire hazard. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of the facility's P&P titled Sanitation (undated) showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. The plastic ware, China, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. The plastic ware is bleached as necessary to prevent staining. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 3/17/25 at 0812 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the RD and Assistant DSS. The following was observed and verified by the RD and Assistant DSS: - Two slotted scoop with black handles partially melted. - One stainless steel slotted spatula with cream handle discolored and partially melted. - One slotted serving spoon with black handle partially melted. - Three slotted scoops with black handles were partially melted. - One scoop with black handle was partially melted. - One scoop with blue handle was partially melted. The RD and Assistant DSS acknowledged the above findings and stated worn out utensils and utensils with melted handles should have been replaced for infection control purposes. 3. Review of the facility's P&P titled Sanitation (undated) showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/17/25 at 0812 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the RD and Assistant DSS. The following was observed and verified by the RD and Assistant DSS: - One cutting knife with white handle and one cutting knife with black handle were observed fuzzy, had cloudy film and dry, crusted residue on the blade. - Two slotted scoops with green handles were dirty and had cloudy film and dry residue. - One scoop with black handle was dirty with dry, crusted residue and had dry watermark and cloudy film. - Two serving spoons with black handles had dry watermarks and cloudy film. - One stainless steel spatula with cream handle had dry, crusted residue and cloudy film. - One slotted serving spoon with black handle had cloudy film. - One stainless steel scoop was dirty with dry, crusted residue. The RD and Assistant DSS acknowledged the above findings and stated all the utensils should have been washed properly for infection control purposes. 4. Review of the facility's P&P titled Sanitation (undated) showed separate chopping boards are to be used for preparing meats and vegetables. After each use, chopping boards shall be thoroughly cleaned and sanitized. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 3/17/25 at 0812 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the RD and Assistant DSS. The yellow, brown and green cutting boards were observed fuzzy, heavily marred and had deep groves. The RD and Assistant DSS verified the findings, and the RD stated the cutting boards were changed last month. The Assistant DSS stated they should have been replaced because it was an infection control issue. 5. Review of the facility's P&P titled Procedure for Freezer Storage (undated) showed each of the freezer must have two thermometers that are easily visible. In addition, review of the facility's P&P titled Sanitation (undated) showed the correct temperatures for the storage and handling of foods are used. The thermometers will be used to check the temperatures of the refrigerators, freezers, and food storeroom. The thermometers will also be used to check the food at mealtimes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USDA Food Code 2022, Section 4-204.112, the placement of the temperature measuring device is important. If the device is placed in the coldest location in the storage unit, it may not be representative of the temperature of the unit. Food could be stored in areas of the unit that exceed Code requirements. Therefore, the temperature measuring device must be placed in a location that is representative of the actual storage temperature of the unit to ensure that all time/temperature control for safety foods are stored at least at the minimum temperature required. On 3/17/25 at 0812 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the RD and Assistant DSS. The chest freezer used for ice cream storage had no external and internal thermometer to measure the temperature. The RD and Assistant DSS verified the above findings and stated it needed a thermometer to monitor the freezer's temperature and maintained a certain temperature for ice cream storage. 6. Review of the facility's P&P titled Meal Service (undated) showed the food will be served on the tray line at the recommended temperatures indicated below and recorded on the daily therapeutic menu. The temperature of the foods should be periodically monitored throughout the meal service to ensure proper hot or cold holding temperatures. Further review of the facility's P&P showed the service temperature for milk was 41 degrees or less. Cold food items will be placed on the trays as close to serving time as possible to assure the temperature is below 41 degrees Fahrenheit. The recommended temperature at the delivery to the resident for milk/cold beverages showed less than or equal to 45 degrees. On 3/18/25 at 1136 hours, during the tray line observation, a concurrent observation and interview was conducted with the RD and DSS. The milk beverage had a temperature of 43 degrees Fahrenheit. Furthermore, during the test tray observation with the RD and DSS, the milk beverage had a temperature of 49.1 degrees Fahrenheit. The RD and DSS acknowledged the findings.

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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** 3. Medical record review for Resident 15 was initiated on 3/17/25. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Order Listing Report showed a physician's order dated 2/22/24, to monitor Resident 15's fluid intake and output every shift. Resident 15's physician ordered a fluid restriction of 2000 ml per 24 hours. Review of Resident 15's Order Summary Report showed a physician's order for weekly fluid intake and output evaluation, dated 11/30/23. On 3/20/25 at 1548 hours, an interview and concurrent medical record review was conducted with the DON. Review of Resident 15's MAR for January, February, and March 2025 showed the following documented weekly fluid intake amounts for Resident 15: - on 1/11 and 1/25/25, weekly fluid intake of 1200 ml - on 1/18, 2/1, 2/15, 2/22, 3/1, and 3/15/25, weekly fluid intake of 1400 ml - on 3/8/25, weekly fluid intake of 1500 ml The DON verified the documentation specific to Resident 15's weekly fluid intake amounts (for the above listed dates) was inaccurate. The DON stated most likely the nurses mistakenly calculated and documented daily (versus weekly) fluid intake totals for Resident 15. 2. Medical record review for Resident 20 was initiated on 3/18/25. Resident 20 was admitted to the facility on [DATE], and readmitted on [DATE]. On 3/20/25 at 1322 hours, an interview and concurrent medical record review was conducted with SSD 2. Review of Resident 20's POLST Section D Information and Signatures dated 9/25/24, failed to show a physician's name, telephone number, license number, signature, and date. The SSD 2 verified the findings and stated the POLST should have been accurately completed. On 3/20/25 at 1559 hours, an interview and concurrent medical record review was conducted with the DON. The DON acknowledged the findings and stated the POLST should have been accurately completed and filled out completely. The DON further stated the POLST should have the physician's printed name, telephone number, license number, signature, and date because it was a requirement. Based on interview, medical record review, facility document review, and the facility P&P review, the facility failed to ensure the medical records were complete and accurately maintained for three of 33 final sampled residents (Residents 15, 20, and 123). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Resident 123's MAR failed to show the Protonix (treats conditions that cause too much stomach acid) and humalog insulin (antidiabetic) per sliding scale were administered on 3/3/25 at 0630 hours. The MAR failed to show the tuberculin test was completed on 3/18/25. In addition, the MAR failed to show the hours of sleep monitoring, non-pharmacological interventions, monitoring of side effects of hypnotics, monitoring of signs and symptoms of bleeding related to anticoagulant use, and monitoring of pain level were completed on 3/2/25 for night shift. * Resident 20's POLST dated 9/25/24, under Section D Information and Signatures, showed the physician's name, telephone number, license number, and signature were left blank and undated for six months. * The facility failed to calculate and document accurate weekly fluid intake totals for Resident 15 in accordance with the physician's order. These failures had the potential for the residents' care needs not being met as their medical information was inaccurate and incomplete. Findings: Review of the facility's P&P titled Charting and Documentation revised 5/2007 showed the resident's clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Review of the facility's P&P titled Medication Administration revised 8/2021 showed if the drug is withheld, refused, or given other than at the scheduled time it should be appropriately documented on the MAR. 1. Medical record review for Resident 123 was initiated on 3/19/25. Resident 123 was readmitted to the facility on [DATE]. Review of Resident 123's MDS assessment dated [DATE], showed Resident 123 was cognitively intact. Review of Resident 123's Order Summary Report showed the following physician's orders: - dated 2/6/25, to administer protonix oral tablet delayed release 40 mg one tablet by mouth in the morning for GERD; - dated 2/6/25, to administer Humalog injection solution 100 units/ml as per sliding scale subcutaneously before meals and at bedtime; - dated 2/6/25, to monitor for hours of sleep every evening and night shift; - dated 2/6/25, to monitor and report to MD as needed the effects of hypnotic medications; - dated 2/6/25, to monitor for signs and symptoms of bleeding related to anticoagulation every shift and to notify the physician if any of the following signs and symptoms are present such as passing blood in the urine, severe bruising or bleeding gums; (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	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hills Post Acute	1800 Old Tustin Avenue Santa Ana, CA 92705

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 2/6/25, to monitor pain level using the following scale: 0 = no pain, 1-3 = mild, 4-6 = moderate, and 7-10 = severe every shift; and - dated 2/6/25, to provide non-pharmacological interventions such as massage, toiletted and snacks; - dated 3/17/25, to provide for annual TB test one dose 0.1 ml every evening shift every 365 days, start date 3/18/25. Review of Resident 123's MAR for March 2025 failed to showed the following: - There was no documented evidence Resident 123 was monitored for hours of sleep, side effects of hypnotics, signs and symptoms of bleeding related to anticoagulant use and pain level, and provided with non-pharmacological interventions on 3/2/25, for the night shift. - There was no documented evidence Resident 123 received the protonix and no blood sugar level recorded indicating if the resident needed the humalog insulin on 3/3/25 at 0630 hours. - There was no documented evidence Resident 123 received the tuberculin test on 3/18/25, for the evening shift. On 3/19/25 at 1348 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated the licensed nurse should document right away in the MAR after the medications administration or monitoring were done. LVN 1 further stated if it was not documented, it was not given. LVN 1 verified the missing documentation in Resident 123's MAR for March 2025. On 3/21/25 at 1458 hours, an interview was conducted with the DON. The DON was notified and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure the appropriate infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of infections were implemented. * Resident 139's urinal was placed next to a water pitcher and two cups of juice on the bedside table. * The facility failed to ensure a hand hygiene was performed before touching the GT. * The facility failed to ensure the staff practiced EBP when rendering GT care for one of 33 sampled residents (Resident 24). These failures posed the risk for transmission of disease-causing microorganisms. Findings: 1. On 3/17/25 at 0720 hours, during an observation, Resident 139's urinal was stored on the bedside table next to a water pitcher and two cups of juice. On 3/17/25 at 1030 hours, an observation in Resident 139's room and concurrent interview was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 139's urinal contained approximately 200 ml of urine and was placed next to a water pitcher and two cups of juice on the bedside table. The MDS Coordinator verified the findings and acknowledged there was a potential for contamination of the drinks. 2. Review of the facility's P&P titled Hand Hygiene revised 3/2024 showed hand hygiene is one of the most effective measures to prevent the spread of infection. Studies show that effective hand decontamination can significantly reduce the rate of healthcare associated infection. All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors. Review of the facility's P&P titled Gastrostomy Tube Care revised 1/2022 showed the employee should wash hands before handling gastrostomy tubes and attachments to decrease the risk of infection. On 3/19/25 at 0822 hours, a medication administration observation was conducted with LVN 5. LVN 5 was observed administering medication to Resident 50 via GT. LVN 5 took the piston syringe (disposable irrigation syringe) with gloved hands to check for the GT's proper placement. LVN 5 pulled the privacy curtain with the gloved hands while still holding the piston syringe. LVN 5 proceeded with flushing the GT without performing hand hygiene and changing with new gloves. On 3/19/25 at 0840 hours, an interview was conducted with LVN 5. LVN 5 was informed regarding not performing the hand hygiene after touching the privacy curtain. LVN 5 acknowledged the findings. On 3/21/25 at 1458 hours, an interview was conducted with the DON. The DON was 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
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. According to the CDC, EBP are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition. Review of the facility's signage for EBP showed everyone must clean their hands, including before entering and when leaving the room. It also showed for the providers and staff must wear gloves and gown for the following high-contact resident care activities: dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised date 3/2024 showed EBP: used in conjunction with standard precautions and expand the use of PPE through the use of gown 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 or from resident-to-resident. (e.g., residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs). Medical record review for Resident 24 was initiated on 3/17/25. Resident 24 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 24's H&P examination dated 7/24/23, showed Resident 24 had no capacity to understand and make decisions. Review of Resident 24's Order Summary Report dated 3/18/25, showed a physician's order dated 3/12/25 for EBP: PPE required for high resident contact care activities; and Indication: wounds, indwelling medical device every shift. Review of Resident 24's plan of care showed a care plan focus addressing Resident 24's Respiratory MDRO and an intervention dated 3/14/25, showed to use EBP. On 3/17/25 at 1003 hours, an observation of Resident 24 and concurrent interview was conducted with RN 4. Resident 24's room was observed with an orange sticker for EBP posted by the door. RN 4 was observed standing at the bedside and troubleshooting the GT feed tubing, priming the line and machine. RN 4 was only wearing the gloves but did not wear the gown and mask. RN 4 verified the orange sticker by the door and stated it was for EBP. RN 4 verified she should have donned PPE, and did not realize Resident 24 was on EBP.