STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555765	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HILLS POST ACUTE	**1800 OLD TUSTIN ROAD SANTA ANA, CA 92705**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the residents' needs were accommodated. The facility failed to ensure the call light was within reach for one of four sampled residents (Resident 1) and one nonsampled resident (Resident A). This failure posed the risk of the residents' needs not being met in a timely manner. Findings: 1. On 8/17/2020 at 0830 hours, an observation was conducted in Resident 1's room. CNA1 was observed providing care to Resident 1. When finished providing care, CNA 1 left the room without placing the call light button within the resident's reach. The call light was observed on the floor behind the head board. On 8/17/2020 at 0840 hours, Resident 1 was observed looking around and tapping the bed with his right hand. When asked if he was looking for something, Resident 1 nodded and gestured by pressing with his right thumb. On 8/17/2020 at 0845 hours, an interview was conducted with CNA1. CNA1 stated Resident 1 was able to use his call light and verified the call light was not within Resident 1's reach. Medical record review for Resident 1 was initiated on 8/17/2020. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's history and physical examination [REDACTED]. Review of Resident 1's plan of care showed a care plan problem addressing Resident 1's risk for falls was initiated on 1/27/2020. The interventions included to ensure the call light was within reach and encourage the resident to use the call light to call for help as needed. 2. On 8/17/2020 at 0855 hours, an observation and concurrent interview was conducted in Resident A's room. Resident A was observed lying in bed. The call light was observed hanging on the wall and not within Resident A's reach. CNA 2 verified the findings. Medical record review for Resident A was initiated on 8/17/2020. Resident A was admitted to the facility on [DATE]. Review of Resident A's plan of care showed a care plan problem addressing the risk for communication problem was initiated on 6/7/19. The interventions included to ensure the call light was within reach. On 8/17/2020 at 1418 hours, an interview and concurent medical record review was conducted with the ADON. The ADON verified the above findings.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure one of four sampled residents (Resident 1) free from physical abuse. CNA 7 was observed by another staff hitting Resident 1 on the right thigh during incontinence care. This failure had the potential to cause physical and/or psychosocial harm to the resident. Findings: Review of the Report of Suspected Dependent Adult/Elder Abuse (SOC 341) submitted by the facility on 7/27/2020, showed the Hospitality Aide (employed by the facility to work alongside the nursing staff, provides non-nursing or non-direct care to the residents) reported witnessing CNA 7 hitting Resident 1 on the leg while providing care. Medical record review for Resident 1 was initiated on 8/17/2020. Resident 1 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 1 had severe cognitive impairment. Review of the Progress Notes showed an entry from the IDT dated 7/27/2020, showing the IDT had met to discuss the incident on 7/26/2020, when CNA 7 was assisted by the Hospitality Aide in providing care to Resident 1. Resident 1 became combative and started striking out towards CNA 7. The Hospitality Aide reported when Resident 1 hit CNA 7 on the arm, CNA 7 struck Resident 1 on the right thigh with her hand. On 9/1/2020 at 1254 hours, a telephone interview was conducted with the Hospitality Aide. The Hospitality Aide stated Resident 1 was usually combative towards the staff. The Hospitality Aide stated during the 0700 to 1500 hours shift (she could not remember the date), at around 1430 hours, she assisted CNA 7 in providing incontinence care to Resident 1. Resident 1 became combative and hit CNA 7. CNA 7 then hit Resident 1 on the right thigh . The Hospitality Aide stated she asked why CNA 7 hit Resident 1, to which CNA 7 responded, .he hit me. The Hospitality Aide stated CNA 7 told her not to tell anyone. Review of the Administrator's conclusion of the investigation showed the facility substantiated the allegation of abuse by CNA 7 to Resident 1. Cross reference to F609.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review and facility document review, the facility staff failed to immediately report a suspected CNA to resident abuse for one of four sampled residents (Resident 1). The Hospitality Aide (employed by the facility to work alongside the nursing staff, provides non-nursing or non-direct care to the residents), who witnessed CNA 7 hitting Resident 1 while providing incontinence care, failed to report the incident immediately. This failure has delayed the investigation process to identify abusive behavior by CNA 7 and has posed Resident 1 at risk of physical injury. Findings: Review of the Report of Suspected Dependent Adult/Elder Abuse (SOC 341) submitted by the facility on 7/27/2020, showed the Hospitality Aide reported witnessing CNA 7 hitting Resident 1 on the leg while providing care. Review of the facility's P&P titled Abuse: Prevention of and Prohibition Against revised on 11/28/17, showed all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. Medical record review for Resident 1 was initiated on 8/17/2020. Resident 1 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 1 had severe cognitive impairment. Review of the Progress Notes showed an entry from the IDT dated 7/27/2020, showing the IDT had met to discuss the incident on 7/26/2020, when CNA 7 was assisted by the Hospitality Aide in providing care to Resident 1. Resident 1 became combative and started striking out towards CNA 7. The Hospitality Aide reported when Resident 1 hit CNA 7 on the arm, CNA 7 struck Resident 1 on the right thigh with her hand. On 9/1/2020 at 1254 hours, a telephone interview was conducted with the Hospitality Aide. The Hospitality Aide stated Resident 1 was usually combative towards the staff. The Hospitality Aide stated during the 0700 to 1500 hours shift (she could not remember the date) at around 1430 hours, she assisted CNA 7 in providing incontinence care to Resident 1. Resident 1 became combative and hit CNA 7. CNA 7 then hit Resident 1 on the right thigh . The Hospitality Aide stated she asked why CNA 7 hit Resident 1, to which CNA 7 responded, .he hit me. The Hospitality Aide stated CNA 7 told her not to tell anyone. The Hospitality Aide stated she did not report the incident right away because she was scared of being retaliated by CNA 7. The Hospitality Aide stated she told RNA 1 about the incident on 7/27/2020, and was escorted to the Administrator. On 9/11/2020 at 1440 hours, an interview was conducted with RNA 1. RNA 1 verified the above findings. On 9/11/2020 at 1440 and 1615 hours, a telephone interview was conducted with the ADON. The ADON verified the alleged abuse incident occurred on 7/25/2020, and was not reported until 7/27/2020. Cross reference to F600.

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

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.