

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2024
NAME OF PROVIDER OR SUPPLIER  Hemet Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1717 West Stetson Avenue Hemet, CA 92545	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43396</p> <p>Based on interview and record review, the facility failed to ensure a care plan was developed, for one of three residents (Resident C), when:</p> <ol style="list-style-type: none"> <li>1. Resident C had an order for a brace (restricting movement and relieving pressure to promote healing) to be applied to the right arm due to fracture (broken bone); and</li> <li>2. Resident C had a diagnosis of congenital deafness (hearing loss that is present at birth) and required the use of white board for communication.</li> </ol> <p>These failures had the potential to have a delay in treatment and services to maintain or improve the highest practicable physical, mental, psychosocial well-being of Resident C.</p> <p>Findings:</p> <p>On March 5, 2024, at 9:30 a.m., an unannounced visit to the facility was conducted to investigate a complaint regarding quality of care.</p> <p>On March 5, 2024, Resident A's record was reviewed. Resident C was admitted to the facility on [DATE], with diagnoses which included altered mental status (define), diabetes mellitus (high blood sugar), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), heart disease, and chronic kidney disease (condition in which the kidneys [are two bean-shaped organs] are damaged and cannot filter blood as well as they should).</p> <p>A review of Resident C's Progress Notes, for the following dates indicated:</p> <ul style="list-style-type: none"> <li>- December 16, 2023, at 2:41 p.m. - .admitted a [AGE] years old male .primary diagnosis of .congenital deafness .</li> <li>- December 16, 2023, at 2:43 p.m. - .white board .marker left in room (sic) for pt (patient)/staff communication. Pt reads white board well .</li> </ul> <p>A review of Resident C's Order Summary Report, dated December 18, 2023, indicated, .Okay to wear brace for the right arm fracture .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence a care plan to include interventions to address Resident A's use of the brace for the right arm due to fracture and/or the use of the white board for communication were developed.</p> <p>On April 3, 2024, at 2:15 p.m., an interview and record review were conducted with the Director of Nursing (DON). The DON stated there was a physician order on December 18, 2023, for Resident A to wear a brace to his right arm due to fracture. The DON stated a care plan to include specific interventions to address Resident A's use of the brace to his right arm for the fracture should have been developed. In addition, she stated Resident A was admitted with a diagnosis of congenital deafness and uses a white board for communication to the staff. The DON stated a care plan to include interventions to address Resident A's use of the white board for communication to the staff should have been developed.</p> <p>The facility's policy and procedure titled Care Plans- Baseline, dated December 2016, indicated, .To assure that the resident's immediate needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. The Interdisciplinary Team will review the healthcare practitioner's order .implement a baseline care plan to meet the resident's immediate care needs including but not limited to .initial goals based on admission orders .physician orders .social services .The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan .</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43396</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided, for one of three residents (Resident A) who required close monitoring and supervision, when Resident A was left unsupervised during care.</p> <p>This failure resulted in Resident A to have wandered into Resident B's room and hit Resident B multiple times while she was lying in bed.</p> <p>Findings:</p> <p>On March 5, 2024, at 9:30 a.m., an unannounced visit to the facility was conducted to investigate a facility reported incident regarding resident-to-resident abuse.</p> <p>On March 5, 2024, at 9:50 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident A was found by staff standing over Resident B's bed in the room on February 19, 2024, at around 8:45 p.m. The DON stated Resident A wandered into Resident B's room, screamed, yelled at Resident B for unknown reason and hit Resident B in the head multiple times. The DON stated Residents A and B reside in different rooms and Resident A had wandered into Resident B's room without staff knowing. The DON stated Resident A was recently sent to the hospital for further evaluation and has not returned to the facility. The DON stated Resident B was discharged to home.</p> <p>On March 5, 2024, at 12:08 p.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 stated resident A has history of being verbally aggressive towards staff by yelling, screaming, cursing, and spitting. RN 1 stated resident A required a sitter (an individual who provides close monitoring to patient to reduce risk and incident of harm). RN 1 also stated Resident A would wander around the hallway but must have a sitter or staff with her at all times. RN 1 further stated the staff liked to keep Resident A close to the Nursing Station so that they can closely monitor her.</p> <p>On March 5, 2024, Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with diagnoses which included dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities).</p> <p>A review of Resident A's care plan, indicated the following:</p> <ul style="list-style-type: none"> <li>- October 16, 2023, indicated, .Verbal/physical agitation/aggression, Episodes of cursing and threatening staff/sitter r/t (related to) dementia .Will not be verbally aggressive towards others .will not harm self or others .; and</li> <li>- October 15, 2023, indicated, .At risk for falls due to .dementia .interventions .1:1 Companion .</li> </ul> <p>A review of Resident A's Minimum Data Set (MDS - an assessment tool), dated January 9, 2024, indicated Resident A had a BIMS (Brief Interview of Mental Status) of 8 (moderately impaired cognitive status).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- February 19, 2024, at 11:31 p.m. - .Patient is confused, restless agitated (sic). Patient requires sitter at all times .Recommendations: Continue to monitor and assign a sitter at all time .</p> <p>On March 5, 2024, Resident B's record was reviewed. Resident B was admitted to the facility on [DATE], with diagnoses which included cellulitis (a type of skin infection) of the right upper limb.</p> <p>A review of Resident B's Minimum Data Set (MDS- an assessment tool), dated January 19, 2024, indicated Resident B had a BIMS (Brief Interview of Mental Status) score of 13 (cognitively intact).</p> <p>A review of Resident B's Progress Notes, dated February 19, 2024, at 9:45 p.m., .Spoke with patient and stated that around 8:45 p.m., she noticed someone came to her room and she thought she's a nurse. Per patient, she realized it's another patient and not a nurse. The female resident told her to sit up and realized the female resident did not have a shirt on. Then, the female patient kneeled on her bed and brought her face towards hers. Per patient, she immediately pulled her blanket up to cover her face, and that is when the female patient started hitting her on the right side of her head and said, I'm going to kiss you.</p> <p>On March 6, 2024, at 11:05 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated on February 19, 2024, she was assigned to Resident A and Resident B. CNA 1 stated at around 8:45 p.m., she observed Resident A from the hallway, sleeping in bed in her room as she was watching her closely. CNA 1 stated that she had asked another CNA to watch over Resident A while she used the restroom. CNA 1 stated after she came back (seven minutes after) from the restroom, Resident A was not found in her bed. CNA 1 stated while her and another CNA went to look for Resident A, they heard noise coming from Resident B's room. CNA 1 stated when they entered Resident B's room, they found Resident A standing over Resident B's bed, yelling, screaming and with her shirt off. CNA 1 stated she immediately redirected Resident A back to her room. CNA 1 interviewed Resident A and stated that the women who came into her room yelled, screamed, and hit her on the head multiple times. CNA 1 stated Resident A required a sitter 24/7 (24 hours/ 7 days a week) due to her behavior of screaming, yelling, and hitting staff. CNA 1 stated on February 19, 2024, the sitter was only at the facility for four hours and she did not know why. CNA 1 further stated after speaking with the CNA who she had asked to watch over Resident A while she used the restroom, as to how Resident A wandered to Resident B's room if she was watching her. This CNA stated that she must have left Resident A unsupervised while she went to check on another resident.</p> <p>On March 6, 2024, at 3:53 p.m., an interview was conducted with the DON. The DON stated Resident A is confused and had behaviors of screaming, yelling, and hitting staff. The DON stated that they were also monitoring Resident A whereabouts to prevent accident due to history of fall. Therefore, the DON stated that Resident A required a sitter 24/7. The DON further stated when sitter is not available for Resident A, the regular staff would have to watch over her at all times. The DON stated the incident on February 19, 2024, involving Resident A and Resident B could have been avoided. The DON further stated the CNA who was asked to watch over Resident A, while CNA 1 went to the restroom, should have waited for CNA 1 to return or to have asked another staff to watch Resident A in her room before she went to care for another resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy and procedure titled Safety and Supervision of Residents, dated March 2019, was reviewed. The policy indicated, .Our facility services to make environment as free from accidents hazards a possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Employee shall be trained on potential accidents hazards and demonstrate competency .try to prevent avoidable accidents .The care team shall target interventions to reduce individual risk related to hazards in the environment, including adequate supervision .assigning responsibility for carrying out interventions .Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risks factors and environmental hazards include .Unsafe wandering .</p>		