STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555297	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemet Hills Post Acute	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46509 Based on observation, interview, and record review the facility failed to ensure new interventions were initated to prevent fall incidents, for one of three residents (Resident C) when Resident C had fall episodes on March 6, 9, 15, 18, 20, and 26, 2024. This failure resulted to Resident C experiencing multiple falls and had the potential for further falls with injury and could compromise overall health condition. Findings: On April 22, 2024, at 12:00 p.m., an unannounced visit to the facility for the investigation of two complaints was conducted. On April 23, 2024, at 11:50 a.m., a review of Resident C's medical record was conducted. Resident C was admitted to the facility on [DATE], with diagnoses which included sarcopenia (age related progressive loss of muscle mass and strength), transient ischemic attack (TIA- a brief stroke-like attack resolving within minutes to hours), and multiple falls. Resident C's history and physical, dated December 22, 2023, indicated . received patient from [name] hospital after falling at home .safety/fall precautions . Resident C's progress notes titled SBAR (situation, background, assessment, and recommendation-a structured communication framework) Summary for Providers, dated March 26, 2024, at 8:25 p.m., indicated Fall , no further documentation regarding incident was found or assessment completed. Resident C's care plan, initiated March 6, 2024, indicated, .Falls: Resident had an unwitnessed fall and is at risk for change in neurological status, injury. recurring falls. Unwitnessed falls 3/6 (March 6), 3/9 (March 9), 3/15 (March 15), 3/18 (March 18), 3/20 (March 20), 3/26 (March 26) .Interventions .anticipate and meet needs (March 6, 2024) .educate/remind resident to call for assistance (March 6, 2024) .monitor needs for rest and assist back to bed as needed (initiated: 04/15/2024 [April 15, 2024]) . Further review of Resident C's care plan, did not indicate new interventions initiated to address each fall incident on March 9, 15, 18, 20, and 26, 2024. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident C's progress notes, there was no no documented evidence the IDT (Interdisciplinary Team - a group of healthcare professionals) reviewed Resident C's each fall incidents and initiated new interventions to prevent future falls. On April 23, 2024, at 1:36 p.m., an interview was conducted with Resident C. Resident C stated he had vision issues and could barely see. Resident C stated he needed assistance in changing his adult briefs when he gets soiled but the staff would take a long time to respond to his call for assistance. On April 23, 2024, at 3:30 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident C fell on [DATE], 15, 18, 20, and 26, 2024. The DON stated intervention to address Resident C's fall on March 6, 2024 was initiated. She stated there were no new interventions to address Resident C's fall on March 9, 15, 18, and 20, 2024. The DON stated there was no documentation the Interdisciplinary Team (IDT) met or reviewed Resident C's multiple falls during the month of March 2024. The DON stated Resident C's risks and vulnerabilities were not analyzed and interventions were not re-evaluated to see if additional interventions were needed to ensure Resident C's safety. Review of the facility's policy titled, Accidents and Incidents-Investigation and Reporting , dated July 2017, indicated .All accidents or incidents involving residents .occurring on our premises shall be investigated and reported .date and time the accident occurred .nature of the injury/illness .fall .where the accident or incident took place .injured person's account of the accident or incident .any corrective action taken . Incident/Accident reports will be reviewed .for trends related to accident or safety .analyze any individual resident vulnerabilities . Review of the facility's policy and procedure titled, Acute Condition Changes-Clinical Protocol , dated March 2018, indicated .nursing staff will review the details of any recent hospitalization and will identify any complications .or the risk of having additional complications .discuss possible causes of the condition change based on factors including resident/patient history .staff monitor a resident/patient with a recent acute change of condition until a problem or condition has resolved . Review of the facility's policy titled, Falls and Fall Risk, Managing , dated March 2018, indicated .the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling .Fall risk factors, environmental factors .footwear that is unsafe or absent .conditions .infection . lower extremity weakness .functional impairments .visual deficits .incontinence .Medical factors .balance and gait disorders .implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls .initial approaches might include exercise and balance . improving footwear .fall mats .if falling recurs .implement additional or different interventions, or indicate why the current approach remains relevant . staff will try various interventions .until falling is reduced or stopped . staff will monitor and document each resident's response to interventions .re-evaluate the situation and whether it is appropriate to continue or change current interventions . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Falls-Clinical Protocol, dated March 2018, indicated .a few individuals fall repeatedly. These individuals often have an identifying underlying cause .details on how fall occurred .IDT will identify medical conditions affecting fall risk .identify possible causes within 24 hours of the fall .IDT will review the situation and help further identify causes and contributing factors .Nursing interventions include visual checks .a sitter .staff will respond to alarms in a timely manner .monitor and document the individual's response to interventions intended to reduce falling .