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	05/21/2024

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 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** 48240 Based on observation, interview, and record review, the facility failed to provide showers twice per week for one of three residents (Resident 1). This failure had the potential to result for Resident 1 to develop body odor, skin breakdown and had the potential to affect Resident 1 ' s overall wellbeing. Findings: On May 22, 2024, at 8:11 a.m., an unannounced visit was conducted at the facility to investigate quality care issues. On May 22, 2024, at 9:27 a.m., during a concurrent observation and interview with Resident 1 in his room, Resident 1 was sitting on his wheelchair, alert and conversant. Resident 1 stated he did not receive shower a couple of times. A review of Resident 1 ' s medical records indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included anoxic brain damage (complete lack of oxygen to the brain), legal blindness (complete loss of sight) and quadriplegia (a person ' s both arms and both legs stop working). Resident 1 ' s Minimum Data Set (MDS- an assessment tool) dated February 21, 2024, indicated Resident 1 ' s ability to understand and make decisions was intact. The MDS indicated, Resident 1 was incontinent to bladder and bowel habits. The MDS further indicated Resident 1 required substantial/maximal assistance helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene and personal hygiene; and was dependent (resident does none of the effort to complete the activity) with shower. On May 22, 2024, at 10:08 a.m., during an interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated residents in the facility are scheduled to have two showers per week and as needed. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 22, 2024, at 11:52 a.m., a concurrent interview with the Director of Staff Development (DSD) and record review of Resident 1 ' s medical record was conducted. The DSD stated Resident 1 ' s shower schedule was every Monday and Thursday evening. The DSD stated Resident 1 was scheduled to receive shower on the following dates: April 29, 2024, May 2, 6, 9, 13, 16 and 20, 2024. The DSD stated there was no documented evidence that Resident 1 received showers on the following dates: May 2, 6, 13, and 20, 2024. The DSD stated it was important for Resident 1 to receive shower to maintain good hygiene and good skin condition. The DSD further stated the CNAs should document when they provide showers to residents. On May 22, 2024, at 2:58 p.m., a concurrent interview with the Registered Nurse Supervisor (RNS), who was also covering for the Director of Nursing, and record review of Resident 1 ' s shower task documentation was conducted. The RNS stated residents in the facility received showers twice a week. The RNS stated Resident 1 did not receive showers as scheduled. The RNS stated the CNAs provided the shower but did not document. The RNS stated if the shower was not documented, then it was not provided. The RNS further stated skin breakdown can develop when showers are not provided. A review of the facility ' s policy and procedure titled, Bath, Shower, dated February 2018 was reviewed. The policy indicated .offer shower or bed bath at least twice a week . documentation .the date and time the shower was performed .the name and title of the individual(s) who assisted the resident with the shower . A review of the facility ' s policy and procedure title, Activities of Daily Living (ADL), Supporting, was reviewed. The policy indicated .residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain . grooming and personal . hygiene . appropriate care and services will be provided for resident who are unable to carry out ADLs independently, with the consent of the resident an in accordance with the plan of care, including appropriate support and assistance with . hygiene (bathing .) .

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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** 48240 Based on interview and record review, the facility failed to address one of three sampled residents' (Resident 2) multiple episodes of poor meal intake and refusal of meals. In addition, Resident 2 was not consistently provided with food substitutes, during episodes of poor intake and refusals of meals. These failures increased Resident 2's risk for inadequate nutrition and hydration. Findings: On May 21, 2024, at 8:11 am, an unannounced visit was conducted at the facility to investigate quality care issues. A review of Resident 2 ' s medical record indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses which included vascular dementia (impaired blood flow to the brain causing changes to memory, thinking and behavior), depression (mental illness), dysphagia (difficulty swallowing). A review of Resident 2 ' s Minimum Data Set (MDS- an assessment tool) dated April 10, 2024, indicated Resident 2 ' s cognition was moderately impaired, and Resident 2 required supervision with eating. A review of Resident 2 ' s meal intake indicated Resident had multiple episodes of poor meal intake and refusal of meals from April 22, 2024, up to May 15, 2024. A review of Resident 2 ' s care plan indicated Resident 2 had Nutritional Status as evidenced by actual weight loss . in 30 days 1/8/24 (sic) d/t (due to) . may refuse be weighed, refuses care and showers, refusing meals and supplements, need for appetite stimulant . The care plan had interventions which included . provide additional calories/protein at meals per patient preference . There was no documented evidence that food substitutes was offered to Resident 2 when Resident 2 had poor meal intake and refused meals. On May 21, 2024, at 10:08 a.m., an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated Resident 2 needed help with eating and often requested apple or cranberry juice and Ensure (a ready-to-drink shake) , which were provided. CNA 1 stated reporting Resident 2's eating difficulties to the charge nurse. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 21, 2024, at 1:54 a.m., a concurrent interview with CNA 2 and record review of Resident 2's meal intake from April 22, 2024, to May 15, 2024, was conducted. CNA 2 stated they are responsible for monitoring residents ' meal intake every meal. CNA 2 stated if a resident did not finish the meal, she tried to find out the reason, offer a substitute and report to the charge nurse when meal intake was less than 50%. CNA 2 stated based on recorded meal intakes, Resident 2 had poor appetite and had refused meals. CNA 2 stated some CNAs did not document Resident 2 ' s meal intake every meal. CNA 2 stated Resident 2 liked to eat dessert, drink apple juice, cranberry juice and Ensure. CNA 2 stated it was important that every meal intakes are documented so that staff are in the same page. On May 21, 2024, at 2:24 p.m., an interview was conducted with Director of Staff Developer (DSD). The DSD stated CNAs were responsible for monitoring residents ' meal intakes every meal. The DSD stated if residents refused meals, the CNAs could offer substitutes to the residents. The DSD stated there was no documented evidence that Resident 2 was provided with food substitutes when he had poor oral intake and refused meals. The DSD stated when residents were not eating and were not drinking, these residents could develop weight loss, failure to thrive, dehydration, bladder infections, malnutrition, and skin breakdown. On May 21, 2024, at 2:58 p.m., a concurrent interview with the Registered Nurse Supervisor (RNS) and record review of Resident 2 ' s meal intake from April 22, 2024, to May 15, 2024, was conducted. The RNS stated Resident 2 had episodes of refusing meals and poor oral intake and that meal intakes were not being monitored every meal. The RNS stated Resident 2 was not receiving enough nutrition based on their documentation. The RNS stated when residents eat less than 50% of meals or refused meals, the CNAs should report to the licensed nurse. The RNS stated the licensed nurse should then inform the physician and the dietitian. The RNS further stated that substitutes should be offered to the residents as well. The RNS stated a CNA notified the charge nurse on May 3 and 9, 2024 about Resident 2 ' s poor meal intake. The RNS stated there was no documented evidence that the charge nurse followed up or notified the physician on May 3 and 9, 2024. On May 22, 2024, at 4:07 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated Resident 2 required set up with meals and liked foods that he can hold with his hand. The RD stated Resident 2 eats good and drinks well if everything was within his reach. The RD stated Resident 2 was resistant to being assisted with meals and got angry. The RD stated Resident 2 ' s oral intake / appetite varies depending on his mood. The RD stated when residents have poor meal intake, CNAs should inform the licensed nurse and the licensed nurse should reach out to her. The RD further stated no one has informed her about Resident 2 ' s poor oral intake and refusal of meals between April 22, 2024, to May 15, 2024. A review of the facility ' s policy and procedure titled, Nutrition and Hydration dated October 2010 was reviewed. The policy indicated, if intake continues to be inadequate, impractical, or impossible, nutritional support must be implemented according to the plan of care . encourage the resident to eat as many calories and as much as tolerated . provide small, frequent meals and/or between-meal snacks to reach caloric and protein goals .