

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 06/19/2024
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure an assessment for self-administration of medication was conducted, for one of eight residents (Resident 2).</p> <p>This failure had the potential to result in an unsafe self-administration of medication by Resident 2.</p> <p>Findings:</p> <p>On June 6, 2024, at 8 a.m., an unannounced visit was conducted at the facility to investigate a complaint intake.</p> <p>On June 6, 2024, at 08:25 a.m., Resident 2 was observed lying in bed. Two bottles of eye drops labeled brimonidine HCL 0.2% (eye drop medication to lower pressure in the eyes) and dorzolamide HCL 0.2 % (eye drop medication to treat increased pressure in the eyes) was observed in the resident's open bedside dresser. In a concurrent interview with Resident 2, he stated the eye drop medications were his and they were kept at his drawer. Resident 2 stated he administers his own eye drop medications by himself.</p> <p>On June 6, 2024, at 5:10 p.m., a concurrent interview and record review was conducted with the DON. The DON observed and confirmed the two bottles of eyedrop medications in Resident 2's drawer at bedside should be secured. Resident 2'd record was concurrently reviewed with the DON. The DON stated Resident 2 had a physician's order for brimonidine and dorzolamide eye drop medication. The DON stated there was no assessment for Resident 2 to self-administer. The DON stated an assessment for self-administration should be done prior to Resident 2 administering the eye drop medications by himself.</p> <p>On June 10, 2024, at 11:08 a.m., an interview was conducted with the Licensed Vocational Nurse, (LVN 3). LVN 3 stated she was aware of Resident 2's medication at the bedside since his transfer from station 1 and Resident 2 would administer the eye drop medications himself. LVN 3 stated there was no evaluation or assessment completed regarding self-administration of medications. She stated she should have made sure an evaluation was done prior to administration. She stated there should be a physician's order, and then a self-administration evaluation completed by a licensed nurse.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2's clinical record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included hypotension (low blood pressure), cerebral infarction (disrupted blood flow to the brain), and Parkinson Disease (a disorder of the central nervous system that affects movement). There was no documented evidence that Resident 2 was assessed for self-administration of medicine.</p> <p>A review of the facility's policy and procedure titled Administering Medications, revised April 2019, indicated, . Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely .</p> <p>A review of facility's policy and procedure titled Self-Administration of Medications, revised February 2021, indicated, .Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure resident's equipment are kept clean and sanitary, for one of eight residents reviewed (Resident 1), when Resident 1's wheelchair safety belts contained layers of dry crusted food.</p> <p>This failure has the potential for Resident 1 to continue to have an unclean environment and further develop infections.</p> <p>Findings:</p> <p>On June 6, 2024, at 8 a.m., an unannounced visit was conducted at the facility to investigate a facility reported incident and complaint intake.</p> <p>On June 6, 2024, at 09:20 a.m., Resident 1 was observed sitting in his wheelchair in front of the nurse's station. Resident 1's wheelchair safety belts was observed placed around his waist. The safety belts were noted dirty and contained layers of dry crusted food covering the belt straps.</p> <p>On June 6, 2024, at 9:38 a.m., Resident 1 was concurrently observed with Licensed Vocational Nurse (LVN) 1. LVN 1 observed Resident 1's wheelchair safety belts and stated the belts were dirty. LVN 1 further stated it could be dried food on the safety belts. LVN 1 stated the dried food on the wheelchair safety belts was totally unacceptable and should not be there. LVN 1 stated the wheelchair safety belts should be clean.</p> <p>On June 6, 2024, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included, anoxic brain damage (condition where the brain is starved of oxygen), epilepsy (a disorder of the brain characterized by repeated seizures), quadriplegia (symptoms of paralysis that affects all a person's limbs and body from the neck down) and hypertension (high blood pressure).</p> <p>A review of Resident 1's care plan, dated April 15, 2024, indicated, Resident 1 has two seatbelts in the wheelchair to enable him for positioning and sit upright. The intervention indicated to ensure the device is clean and in good repair.</p> <p>A review of the facility's policy and procedure titled, . Assistive Devices and Equipment, revised January 2020 indicated, .Our facility maintains and supervises the use of assistive devices .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure consistent oral care and personal grooming was provided, for one of eight residents (Resident 1).</p> <p>This failure resulted in poor oral hygiene and had the potential to affect Resident 1's dignity and diminish his quality of life.</p> <p>Findings:</p> <p>On June 6, 2024, at 8 a.m., an unannounced visit was conducted at the facility to investigate a complaint intake on quality of life.</p> <p>On June 6, 2024, at 09:20 a.m., Resident 1 was observed sitting in his wheelchair in front of the nurse's station. Resident 1 was observed to have mucus draining from the resident's left nostril. In a concurrent interview with Resident 1, he was well and doing good. While the interview with Resident 1 was being conducted, a foul odor was noticeable coming out from the resident 's mouth.</p> <p>On June 6, 2024, at 09:38 a.m., a concurrent interview and observation with Licensed Vocational Nurse (LVN) 1 was conducted of Resident 1. LVN 1 stated there was fluid coming from Resident 1's left nostril and a strong foul odor coming from the resident's mouth. LVN 1 stated his breath has a foul odor and stated this is totally unacceptable. LVN 1 stated the Resident 1's mouth smelled unpleasant.</p> <p>On June 6, 2024, a record review of Resident 1's chart was conducted. Resident 1 was admitted to the facility on [DATE] with diagnoses which included, anoxic brain damage (condition where the brain is starved of oxygen), epilepsy (a disorder of the brain characterized by repeated seizures), quadriplegia (symptom of paralysis that affects all a person's limbs and body from the neck down), and hypertension (high blood pressure).</p> <p>A review of Resident 1's care plan, dated February 15, 2024, indicated a focus of ADL (Activities of Daily Living)/Mobility, .resident at risk for ADL/mobility decline and requires assistance. Indicated Resident 1's needs are to be anticipated by staff and oral care assistance given .</p> <p>A review of Resident 1's Documentation Survey Report, for the month of May 2024, indicated, there was no documentation oral hygiene was provided to Resident 1 on multiple dates (May 2, 5, 6, 7, 8, 12, 13, 14, 15, 16, 19, 20, 23, 24, 28, 29, and 30, 2024).</p> <p>A review of the facility's policy and procedure titled Activities of Daily Living (ADL), Supporting, dated 2001, indicated, .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .</p>