

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 08/23/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</p> <p>Based on interview and record review, the facility failed to ensure the physician was notified, for one of six residents (Resident 1), when Resident 1 refused to come back inside the facility and had an aggressive behavior including threatening to hurt himself on July 9, 2024.</p> <p>This failure had the potential for the physician to be unaware of Resident 1 ' s condition and delayed provision of possible treatment.</p> <p>Findings:</p> <p>On July 26, 2024, at 2:14 p.m., an unannounced visit to the facility on four complaints and two facility reported incidents were initiated.</p> <p>A review of Resident 1 ' s medical records indicated Resident 1 was admitted on [DATE], with diagnoses of parkinsonism, (a clinical syndrome characterized by tremor, progressive hesitation and halting of body movements, rigidity, and postural instability), dementia, (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), dysarthria, (unclear articulation of speech), and anarthria, (total loss of speech).</p> <p>A review of Resident 1 ' s History and Physical, dated June 21, 2024, indicated he was alert and oriented.</p> <p>A review of Resident 1 ' s Order Summary Report, dated June 26, 2024, indicated .Resident is incapable of giving informed consent .</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1 ' s Progress Notes dated July 9, 2024, at 1:34 a.m., indicated On my way to station 1, patient is found outside the facility hitting on staff/sitter who was encouraging patient to come back inside the facility. Licensed nurse walks to patient and encourages patient to come back into the facility and also (sic) stop hitting the sitter. Patient refuses to listen and start hitting Licensed nurse, Licensed nurse returns back to the room and brings patient w/c and wheels patient back to his room to ensure his safety. Patient continues to hit sitter and licensed nurse. In the room, patient gets upset and throwing (sic) water cups at staffs, (sic) pulling on the room curtains, stating he was going to hurt himself to get start (sic) in trouble, (sic) patient (sic) kept pacing back and forth in the room, grabbing equipment like remote control and sharps and throwing them at staffs (sic) or at himself, stating he was going to mess us up and himself also. Charge nurse notified of the situation.</p> <p>A review of Resident 1 ' s records indicated there was no documentation that the physician was notified on July 9, 2024.</p> <p>On July 29, 2024, at 2:39 p.m., an interview and concurrent record review was conducted with the Licensed Vocational Nurse (LVN 1). LVN 1 stated Resident 1 was admitted with behavioral issues. LVN 1 stated they had provided a sitter for Resident 1. LVN 1 stated that Resident 1 exhibited aggressive behavior and they were able to redirect his behavior. LVN 1 stated on July 9, 2024, at 1:34 a.m., when Resident 1 was observed outside the facility hitting the sitter, throwing water cups, and other equipment at the staff, the doctor should have been notified of the behavior. LVN 1 stated the doctor was not notified on July 9, 2024.</p> <p>A review of the facility ' s policy and procedure titled Charting and Documentation, revised December 2022, indicated .The following information are examples of documentation that may be included in the resident medical record .Changes in the resident's condition, if indicated .</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** 41422</p> <p>Based on observation, interview, and record review, the facility failed to ensure a home like environment was provided, for two of six residents (Resident 2 and Resident 4), when:</p> <ol style="list-style-type: none"> 1. The wall on the left side of the entry door had horizontal black scuff marks along the whole surface of the wall inside Residents 2 and 4's rooms; 2. There was a one inch by one inch dent, with the wallpaper peeling away from the wall surface on the same wall adjacent from Resident 4 ' s bed (closest to the entry door), above the base board; and 3. There were 14 dried orange, brown droplet-like smudges on the wall, baseboard, and the edge of the floor; and approximately six-inch black vertical scuff mark on the same wall, adjacent from Resident 2 ' s bed, (furthest from the entry door). <p>These failures placed the residents at risk for low self-esteem and living in an unkempt environment.</p> <p>Findings:</p> <p>On July 26, 2024, at 2:14 p.m., an unannounced visit to the facility on four complaints and two facility reported incidents were initiated.</p> <p>A review of Resident 2 ' s medical record indicated he was admitted on [DATE], with diagnoses of intervertebral disc degeneration (a condition of the discs between vertebrae with loss of cushioning muscle wasting and atrophy, dorsalgia, presents as localized pain or discomfort in the back), cardiac arrhythmia, (irregular heartbeat), and scoliosis, (a sideways curvature of the spine).</p> <p>A review of Resident 2 ' s History and Physical, dated July 19, 2024, indicated he had the capacity to understand and make decisions.</p> <p>A review of Resident 4 ' s medical record indicated he was originally admitted to the facility on [DATE], with diagnoses of sepsis, (occurs when chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body, that can lead to death), type 2 diabetes mellitus, (a chronic condition that affects the way the body uses sugar. The body either resists the effects of insulin - a hormone that regulates the movement of sugar into the cells - or doesn't produce enough insulin to maintain normal sugar levels), with ketoacidosis, (a life-threatening problem that affects people with diabetes), methicillin resistant staphylococcus aureus infection, (MRSA - an antibiotic resistant organism), extended spectrum beta lactamase resistance, (ESBL - an antibiotic resistant organism), urinary tract infection, (infection in the bladder), benign prostatic hyperplasia, (BPH - enlargement of the prostate gland), and hypotension, (low blood pressure).</p> <p>A review of Resident 4 ' s History and Physical, dated June 14, 2024, indicated he had the capacity to understand and make decisions.</p> <p>(continued on next page)</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>On July 26, 2024, at 3:44 p.m., during observation of Resident 2 and 4 ' s room, there were horizontal black scuff marks along the whole surface of the wall the wall on the left side of the entry door. On the same wall adjacent from Resident 4 ' s bed (closest to the entry door), above the base board, there was a one inch by one inch dent, with the wallpaper peeling away from the wall surface. On the same wall, adjacent from Resident 2 ' s bed, (furthest from the entry door), there were 14 dried orange, brown droplet-like smudges on the wall, baseboard, and the edge of the floor; and approximately six-inch black vertical scuff mark.</p> <p>On July 26, 2024, at 3:51 p.m., an interview was conducted with Resident 4's visitor. Resident 4's visitor stated the dent in the wall and wallpaper peeling up has been there since Resident 4 was admitted . Resident 4's visitor stated she felt like the walls were dirty.</p> <p>On July 26, 2024, at 4:55 p.m., an interview was conducted with Resident 2. Resident 2 stated the dried brown stuff on the wall was gross.</p> <p>On July 26, 2024, at 5:54 p.m. an observation and concurrent interview was conducted with the Certified Nursing Assistant, (CNA 2). CNA 2 observed in Resident 2 and Resident 4 ' s room the wall on the left side of the entry door there were horizontal black scuff marks along the whole surface of the wall. On the same wall adjacent from Resident 4 ' s bed (closest to the entry door), above the base board, there was a one inch by one inch dent, with the wallpaper peeling away from the wall surface. On the same wall, adjacent from Resident 2 ' s bed, (furthest from the entry door), there were 14 dried orange, brown droplet-like smudges on the wall, baseboard, and the edge of the floor; and approximately six-inch black vertical scuff mark.CNA 2 stated that they would notify maintenance and document the dent in the maintenance log at the nurses ' station for repair. CNA 2 stated that housekeeping should be cleaning the rooms daily, and it appears that the wall needs to be cleaned.</p> <p>On July 29, 2024, at 4:05 p.m., observed in Resident 2 and Resident 4 ' s room the wall on the left side of the entry door there were horizontal black scuff marks along the whole surface of the wall. On the same wall adjacent from Resident 4 ' s bed (closest to the entry door), above the base board, there was a one inch by one inch dent, with the wallpaper peeling away from the wall surface. On the same wall, adjacent from Resident 2 ' s bed, (furthest from the entry door), there were 14 dried orange, brown droplet-like smudges on the wall, baseboard, and the edge of the floor; and approximately six-inch black vertical scuff mark.</p> <p>On July 29, 2024, at 5:54 p.m., Resident 2 and 4's room was observed with Certified Nursing Assistant (CNA) 2. CNA 2 observed the same environmental issues initially observed on July 29, 2024 at 4:05 p.m. CNA 2 stated the walls needed to be cleaned and the housekeepers should be cleaning the rooms daily.</p> <p>On July 30, 2024, at 12:37 p.m., an observation and concurrent interview was conducted with the Maintenance Assistant (MAS). Observed in Resident 2 and Resident 4 ' s room the wall on the left side of the entry door adjacent from Resident 4 ' s bed (closest to the entry door), above the base board, there was a one inch by one inch dent, with the wallpaper peeling away from the wall surface. The MAS stated that should have been reported by staff in the maintenance log. The MAS stated he would check the logs daily and documents the date of repair, usually within 24 hours.</p> <p>On July 30, 2024, at 12:37 p.m., a concurrent interview and record review was conducted with the MAS. The MAS reviewed the maintenance log and stated the request for repair had not been documented.</p> <p>(continued on next page)</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>On July 30, 2024, at 12:52 p.m., an interview was conducted with the Housekeeping Director (HD). The HD stated that resident rooms are cleaned daily. The HD stated that surfaces that are cleaned daily included the walls.</p> <p>On July 30, 2024, at 12:54 p.m., a concurrent observation and interview was conducted with the HD. The HD observed in Resident 2 and Resident 4 ' s room the wall on the left side of the entry door there were horizontal black scuff marks along the whole surface of the wall. On the same wall, adjacent from Resident 2 ' s bed, (furthest from the entry door), there were 14 dried orange, brown droplet-like smudges on the wall, baseboard, and the edge of the floor; and approximately six-inch black vertical scuff mark. The HD stated that the wall should have been cleaned up by now.</p> <p>A review of the facility ' s policy and procedure titled Quality of Life - Homelike Environment, revised May 2017, indicated, .Residents are provided with a safe, clean, comfortable and homelike environment .The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .Clean, sanitary and orderly environment .</p> <p>A review of the facility ' s policy and procedure titled Maintenance Service, revised December 2009, indicated, .Functions of maintenance personnel include, but are not limited to .Maintaining the building in good repair .This Center shall maintain a maintenance log of service visits, repairs and inspections of the fixtures, equip ment, systems, and buildings .All staff members who encounter fixtures, equipment, systems or building areas that need repairs or inspections shall log the repair or need in the Maintenance Log . Maintenance Staff are to check the maintenance log daily. Maintenance staff shall initial and date repair/inspection once completed .</p> <p>A review of the facility ' s policy and procedure titled Cleaning and Disinfection of Environmental Surfaces, revised June 2009, indicated, .Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled .Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</p> <p>Based on interview, and record review, the facility failed to ensure a plan of care was developed and/or implemented, for one of six residents (Resident 1) when Resident 1 had episodes of aggressive behavior.</p> <p>This failure had the potential to result in staff not providing care and interventions not being implemented that would affect the residents' highest practicable well-being.</p> <p>Findings:</p> <p>On July 26, 2024, at 2:14 p.m., an unannounced visit to the facility on four complaints and two facility reported incidents were initiated.</p> <p>A review of Resident 1 ' s medical records indicated he was admitted on [DATE], with diagnoses of parkinsonism, (a clinical syndrome characterized by tremor, progressive hesitation and halting of body movements, rigidity, and postural instability), dementia, (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), dysarthria, (unclear articulation of speech), and anarthria, (total loss of speech).</p> <p>A review of Resident 1 ' s History and Physical, dated June 21, 2024, indicated he was alert and oriented.</p> <p>A review of Resident 1 ' s Order Summary Report, dated June 26, 2024, indicated, .Resident is incapable of giving informed consent .</p> <p>A review of Resident 1 ' s Care Plans indicated there was no documented evidence that a care plan had been implemented for Resident 1 ' s aggressive behaviors.</p> <p>On July 29, 2024, at 2:50 a.m., an interview and concurrent record review was conducted with the Registered Nurse (RN). The RN stated that she recalled Resident 1 having aggressive behavior. The RN stated there was no care plan for Resident 1 ' s aggressive behavior. The RN stated that Resident 1 should have had a care plan for his aggressive behavior.</p> <p>A review of the facility ' s policy and procedure titled Care Planning Interdisciplinary Team, revised September 2013, indicated, .Our facility ' s Care planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team .The resident the resident's family .</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</p> <p>Based on interview and record review, the facility failed to provide care and services for activities of daily living (ADLs), for one of six sampled residents (Resident 2), when the resident failed to receive showers as scheduled.</p> <p>This failure had the potential to negatively affect the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>On July 26, 2024, at 2:14 p.m., an unannounced visit to the facility on four complaints and two Facility Reported Incidents were initiated.</p> <p>A review of Resident 2 ' s medical record indicated he was admitted on [DATE], with diagnoses of intervertebral disc degeneration (a condition of the discs between vertebrae with loss of cushioning muscle wasting and atrophy, dorsalgia, presents as localized pain or discomfort in the back), cardiac arrhythmia, (irregular heartbeat), and scoliosis, (a sideways curvature of the spine).</p> <p>A review of Resident 2 ' s History and Physical, dated July 19, 2024, indicated he had the capacity to understand and make decisions.</p> <p>A review of the facility ' s Shower Schedules, indicated Resident 2 ' s shower days were on Wednesday mornings, and Saturday evenings.</p> <p>On July 26, 2024, at 2:41 p.m., an interview was conducted with the Director of Nursing, (DON). The DON stated on July 21, 2024, Resident 2 ' s visitor came to the nurses ' station and was asking about the showers. The DON stated that Resident 2 should have had a shower every Wednesday and Saturday. The DON stated she was going to investigate why Resident 2 did not get a shower until Sunday, July 21, 2024.</p> <p>On July 26, 2024, at 3:41 p.m., an interview was conducted with the Certified Nursing Assistant, (CNA 1). CNA 1 stated that residents are to be offered showers or bed baths twice a week and as needed or requested. CNA 1 stated that they document the showers in the residents ' chart.</p> <p>On July 26, 2024, at 4:55 p.m., an interview was conducted with Resident 2. Resident 2 stated that he was admitted on Wednesday, July 21, 2024. Resident 2 stated he was not offered a shower until Sunday, July 21, 2024. Resident 2 stated he felt unclean without a shower.</p> <p>A review of Resident 2 ' s Bathing Task indicated:</p> <ul style="list-style-type: none"> - On July 18th, 19th, 20th, 2024, indicated, NOT APPLICABLE - On July 21, 2024, at 9:10 p.m., indicated, SUPERVISION or TOUCH ASSIST <p>(continued on next page)</p>		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled Bath, Shower, revised February 2018, indicated, .The purposes of this procedure are to promote cleanliness, provide comfort to the resident .Offer shower or bed bath at least twice a week or according to the preference of the resident or as tolerated .		

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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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</p> <p>Based on interview, and record review, the facility failed to ensure physician order was followed, for one of six residents (Resident 3), when Midodrine (a medication used to increase blood pressure) was not held when the systolic blood pressure, (SBP) was greater than 120.</p> <p>This failure had the potential for Resident 3 to have dangerously high blood pressure.</p> <p>Findings:</p> <p>On July 26, 2024, at 2:14 p.m., an unannounced visit to the facility on four complaints and two Facility Reported Incidents were initiated.</p> <p>A review of Resident 3 ' s medical records indicated he was admitted on [DATE], with diagnoses of stroke, acute kidney failure, (occurs when the kidneys suddenly become unable to filter waste products from the blood), diabetes mellitus type 2, (a chronic condition that affects the way the body uses sugar. The body either resists the effects of insulin - a hormone that regulates the movement of sugar into the cells - or doesn't produce enough insulin to maintain normal sugar levels), and orthostatic hypotension, (a sudden drop in blood pressure upon standing from a sitting or lying position).</p> <p>A review of Resident 3 ' s History and Physical, dated June 21, 2024, indicated he was alert and oriented.</p> <p>A review of Resident 3 ' s Physician Orders, dated May 14, 2024, at 1:12 a.m., indicated, Midodrine HCl (hydrochloride), Oral Tablet 5 MG, (milligrams) .Give 1 tablet by mouth three times a day for Orthostatic Hypotension Do not give If SBP is greater than 120, Do not give last dose or day after 6 PM, or within 4 hours of bedtime</p> <p>A review of Resident 3 ' s Medication Administration Record, dated May 2024, indicated Midodrine was administered on the following days when the SBP was above 120:</p> <p>for Orthostatic Hypotension Do not give if SBP is greater than 120, Do not give last dose of day after 6 PM, or within 4 hours of bedtime -Start Date 05/14/2024 0800 -Hold Date from 05/28/2024 0800 to 05/29/2024 1746 .</p> <p>Doses were documented as given on:</p> <ul style="list-style-type: none"> - May 20, 2024, at 4 p.m., SBP 146; - May 21, 2024, at 9 a.m. SBP 127; - May 21, 2024, at 12 p.m., when SBP was 127; and - May 21, 2024, at 4 p.m., when SBP was 138. <p>(continued on next page)</p>		

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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>On July 29, 2024, at 2:39 p.m., an interview was conducted with the Licensed Vocational Nurse, (LVN 1). LVN 1 stated the Midodrine was to be given to increase the blood pressure. LVN 1 stated they should have held the Midodrine when Resident 3 ' s systolic blood pressure was greater than 120.</p> <p>A review of the facility ' s policy and procedure titled Medication Administration Schedule, revised November 2020, indicated, .Medications are administered according to the following routine schedule per protocol in facility based on the Physician Order .</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</p> <p>Based on interview, and record review, the facility failed to ensure, for one of six residents (Resident 1), was free from unnecessary psychotropic medications (medications used to treat mental illness), when there was no appropriate indication for use for Ativan (medication used to treat anxiety) and Seroquel (medication to treat mental disorders). In addition, an informed consent was not obtained from Resident 1's responsible party for the use of Ativan and Seroquel.</p> <p>These failures had the potential for Resident 1 to receive unnecessary antipsychotic medications.</p> <p>Findings:</p> <p>On July 26, 2024, at 2:14 p.m., an unannounced visit to the facility on four complaints and two facility reported incidents were initiated.</p> <p>A review of Resident 1 ' s medical records indicated he was admitted on [DATE], with diagnoses of parkinsonism, (a clinical syndrome characterized by tremor, progressive hesitation and halting of body movements, rigidity, and postural instability), dementia, (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), dysarthria, (unclear articulation of speech),and anarthria, (total loss of speech).</p> <p>A review of Resident 1 ' s History and Physical, dated June 21, 2024, indicated he was alert and oriented.</p> <p>A review of Resident 1 ' s Order Summary Report, dated June 26, 2024, indicated .Resident is incapable of giving informed consent .</p> <p>A record review of Resident 1 ' s Order Summary Report dated July 11, 2024, indicated:</p> <ul style="list-style-type: none"> - Ativan Oral Tablet 2 MG (Lorazepam) Give 1 tablet by mouth one time only for pyschosis, (sic) m/b agitation until 07/11/2024 July 11, 2024 - SEROquel Oral Tablet 50 MG (Quetiapine Fumarate) Give 1 tablet by mouth two times a day for Psychosis m/b agitation, date ordered April 15, 2024 <p>On July 30, 2024, at 5:15 p.m., an interview and concurrent record review was conducted with the Director of Nursing (DON). The DON stated the order for Ativan with an indication for use of psychosis was not correct. The DON stated Ativan should be used for anxiety. The DON stated the order should have been clarified with the doctor. The DON stated the order for Seroquel with an indication for use of psychosis should have been clarified with the doctor. The DON stated there was no documentation of informed consent for the use of Seroquel or Ativan.</p> <p>(continued on next page)</p>		

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 08/23/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s undated policy and procedure titled Psychoactive/Psychotropic Medication Use, indicated, .The prescribing clinician will obtain informed consent from the resident (or, as appropriate. the resident representative) for use of a Psychotropic medication .General Guidelines .Psychotropic medication is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: Anti psychotic, Antidepressant, Antianxiety, Mood Stabilizer, and Sedative-Hypnotic .Residents will only receive Psychotropic medications when necessary to treat a specifically diagnosed condition that is documented in the medical record .Attending Physician and other staff will gather and document information to clarify, as possible, the resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others . Prior to administration of a Psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative), and document the consent in the medical record .Psychotropic Medication Management a. Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following: indication and clinical need for medication, dose, duration, and adequate monitoring for efficacy and adverse consequences .PRN Psychotropic medication will be used only if necessary to treat a diagnosed specific condition that is documented in the clinical record . A new informed consent must be obtained for dosage increases of Antipsychotic (sic) medication as required by individual state regulations .</p> <p>A review of the facility ' s policy and procedure titled Physician Orders, revised July 2016, indicated, .Orders for medications must include .Number of doses, start and stop date, and/or specific duration of therapy . Clinical condition or symptoms for which the medication is prescribed .</p>		