

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 11/05/2024
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145</p> <p>Based on interview and record review, facility staff failed for one of seven sampled residents (Resident 2) to follow-up on the resident's blood pressure (BP) to assess the effectiveness of the as needed (PRN) BP medication.</p> <p>This failure had the potential to result in not knowing whether the blood pressure medication effectively lowered the resident's blood pressure or if the blood pressure dropped too low after taking the medication.</p> <p>Findings:</p> <p>On October 21, 2024, at 8:58 a.m., an unannounced visit was made to the facility for a quality-of-care issue.</p> <p>A review of Resident 2 ' s medical records, titled, Face sheet, undated, indicated, resident was admitted to the facility on [DATE], with a diagnosis of hypertension {HTN}-high blood pressure).</p> <p>A review of Resident 2 ' s care plan, dated September 15, 2024, indicated:</p> <p>- . complications related (r/t) (HTN) .Interventions . Administer medications as ordered. Observe, document and notify (physician) of adverse side effect . report abnormal findings to (physician) .</p> <p>A review of Resident 2's Minimum Data Set (an assessment tool) dated September 17, 2024, indicated, a Brief Interview for Mental Status ({BIMS}-cognitive assessment) score of 15 (cognitively intact).</p> <p>A review of Resident 2's physician orders, dated September 13, 2024, indicated, cloNIDine .0.1 MG (milligram) .give 0.1 mg by mouth every 8 hours as needed for HTN (hypertension) Give if sbp (systolic blood pressure - top number in a blood pressure reading) > (more than) 160 .</p> <p>A review of Resident 2 ' s BP on September 27, 2024, at 9:00 a.m., indicated, Resident 2's BP was 184/92 mmHg.</p> <p>A review of Resident 2 ' s MAR, on September 27, 2024, at 9:00 a.m., indicated, Clonidine 0.1 MG was administered to Resident 2 as per the physician's order.</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>Further review of Resident 2's MAR indicated there was no documentation showing Resident 2's blood pressure was taken to assess the effectiveness of the Clonidine.</p> <p>A review of Resident 2 ' s progress notes, dated September 27, 2024, indicated LVN 2 documented Resident 2 ' s BP was 184/92 mmHg and administered PRN medication Clonidine 0.1 MG.</p> <p>Further review of Resident 2's progress notes indicated there was no documented follow-up assessment of the resident's BP or the effectiveness of PRN Clonidine one hour post administration.</p> <p>On October 21, 2024, at 4:34 p.m., a concurrent interview and review of Resident 2 ' s MAR and progress notes dated September 27, 2024, were conducted with the Director of Nursing (DON). The DON stated, the PRN Clonidine was administered by LVN 2 at 9 a.m., and Resident 2's BP should have been followed-up within an hour to assess for the effectiveness of Clonidine. The DON stated, it should have been documented.</p> <p>On October 22, 2024, at 9:47 a.m., a concurrent interview and review of Resident 2 ' s September MAR, BP, and progress notes were conducted with LVN 2. LVN 2 stated when giving a PRN BP medication, she would follow-up by rechecking the resident ' s BP in 15 to 30 minutes, documenting the re-checked BP, and noting the effectiveness of the PRN medication on the MAR and in the progress note. LVN 2 further stated, she administered PRN Clonidine at 9 a.m. for Resident 2 ' s BP of 184/92, per physician orders. LVN 2 stated, she should have documented the follow-up BP and the effectiveness of the PRN medication per protocol.</p> <p>A facility policy & procedure titled, Medication Administration General Guidelines, dated, January 2024, indicated, .Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. 2. Obtain a record any vital signs as necessary prior to medication administration . Documentation: 2. If a dose of regularly scheduled medication is withheld . the space provided on front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered . 5. When PRN medications are administered, the following documentation is provided: . c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording . effects . 7. Observe resident . and record in the nurse ' s notes as appropriate .</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145</p> <p>Based on interview and record review, the facility failed to prevent medication errors, as resident 's medications were administered outside of the physician's ordered parameters, for two out of seven sampled residents (Residents 3 and 4).</p> <p>The failure had the potential to cause harm to residents, such as adverse reactions, side effects, or ineffective treatment.</p> <p>Findings:</p> <p>On October 21, 2024, at 8:58 a.m., an unannounced visit was made to the facility for a quality-of-care issue.</p> <p>On October 21, 2024, at 9:20 a.m., an interview was conducted with LVN 1, who stated, the process to administer medications includes, check (vital signs) first, verify physician's orders and ordered parameters (instructions to administer or hold medications depending on vital signs), administer or withhold medications. LVN 1 stated if medications were administered, the nurse would document in resident 's Medication Administration Record (MAR) by initialing under the date and time administered. LVN 1 stated, if medications were held, nurse would document the code 4 (medications outside of parameters) in resident 's MAR, notify the physician, and document in progress note the reason medications were held.</p> <p>1a. A review of Resident 3's medical record, titled, Face sheet, undated, indicated, resident was admitted to the facility on [DATE], with a diagnosis of hypertension ({HTN}-high blood pressure), and atrial fibrillation ({a-fib}-irregular heat beat).</p> <p>Further review of Resident 3's Minimum Data Set (an assessment tool) indicated resident's Brief Interview for Mental Status (Cognitive assessment) score was 12 (cognitively intact).</p> <p>A review of Resident 3's physician's order, dated July 25, 2024, indicated . Amiodarone (a-fib medication) . 200 MG (milligram -a unit of measure) . hold if pulse < (is less than) 70 .</p> <p>A review of Resident 3 's Medication Administration Record (MAR) dated, October 2024, indicated, the medication Amiodarone 200MG was administered outside the ordered parameters of . hold if pulse < (is less than) 70 . between October 1, 2024 through October 22, 2024:</p> <ul style="list-style-type: none"> - October 2, 2024, Pulse 63 - October 4, 2024, Pulse 62 - October 7, 2024, Pulse 69 - October 8, 9, 10, Pulse 64 - October 11, 2024, Pulse 62 <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- October 13, 2024, Pulse 69</p> <p>- October 18, 2024, Pulse 60</p> <p>- October 20, 2024, Pulse 62</p> <p>- October 21, 2024, Pulse 68</p> <p>On October 25, 2024, at 8:45 a.m., a concurrent interview and review of Resident 3 's October MAR were conducted with LVN 1. LVN 1 verified she had administered Resident 3's medication Amiodarone seven out of 11 times, when resident's pulse was less than 70, on the following dates, October 2, 4, 8, 9, 10, 20, and 21, 2024. LVN 1 stated, she was not sure why she had administered the medication outside the ordered parameters, which is to hold for pulse less than 70. LVN 1 stated, she should have withheld the medication Amiodarone, on the above specified dates, as resident's pulse were out of the ordered parameters.</p> <p>1b. A review of Resident 3's care plan dated August 6, 2024, indicated .Resident has had episode of elevated (BP) (related to) . HTN . Interventions . Give (HTN) medications as ordered .</p> <p>A review of Resident 3 ' s physician's orders, dated July 25, 2024, indicated . Lisinopril (BP medication) 20 MG . hold if SBP {Systolic Blood Pressure}-top BP number) < 110 .</p> <p>Further review of Resident 3's MAR dated, October 2024, indicated that Lisinopril 20 mg was administered outside the ordered parameters (hold if SBP < 110) on October 3, 2024 when Resident 3's BP was 108/68.</p> <p>On October 25, 2024, at 8:45 a.m., a concurrent interview and review of Resident 3's October MAR were conducted with LVN 1. LVN 1 stated, she administered Lisinopril on October 3, 2024, when Resident 3's BP was outside the ordered parameters. LVN 1 stated, she was not sure why she had administered the medication, when the resident's SBP was less than 110. LVN 1 stated, she should have withheld the medication Lisinopril, on October 3, 2024, as the resident 's BP was out the ordered parameters.</p> <p>2. A review of Resident 4's, Face sheet, undated, indicated, resident was admitted to the facility on [DATE], with a diagnosis of hypotension (low blood pressure).</p> <p>A review of Resident 3's physician's order, dated September 9, 2024, indicated, .Midodrine (medication to increase low blood pressure) 10GM (gram - unit of measurement) . for low BP . Hold if SBP > (above) 120 .</p> <p>A review of Resident 3's MAR for October 2024, indicated that Midodrine was administered outside the ordered parameters to hold if SBP > 120 on the following dates and times:</p> <p>-October 5, 2024, 8:00 a.m. BP 130/78 (SBP 130)</p> <p>-October 5, 2024, 12:00 p.m. BP 130/78 (SBP 130)</p> <p>-October 12, 2024, 8:00 a.m. BP 137/83 (SBP 137)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On October 25, 2024, at 9 a.m., a concurrent interview and review of Resident 3 & 4's MAR dated October 2024, were conducted with the Director of Nursing (DON). The DON stated the process for nurses to administer medications with ordered parameters, includes the nurse verifying the order and parameters, checking the resident's vital signs (BP and Pulse) and then administering the medications if the vital signs are within the ordered parameters. The DON stated, the nurse must document in the MAR, by initialing the MAR under date and time, once the medication was administered. The DON stated, if the resident's vital signs are outside the ordered parameters, the nurse should document a code 4 or 5 on the MAR, under the date and time, notify the physician, and document a progress note explaining why the medication was held, and indicating the physician was notified. The DON verified both Residents 3 & 4 had been administered medications when their pulse or BP were outside the ordered parameters. The DON stated the licensed nurses were not following orders and should have read the orders closely prior to administering medications.</p> <p>A review of the facilities policy & procedure, dated, January 2024, indicated, . Policy: Medications are administered as prescribed in accordance with manufacturers ' specifications, (&) good nursing principles and practices . Procedures: 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record . Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive . or medication order seems to be unrelated to the resident ' s current diagnosis or conditions . the nurse contacts the prescriber for clarification . the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate . Obtain and record any vital signs as necessary prior to medication administration . Documentation: 1. The individual who administers the medication dose, records the administration on the resident ' s MAR immediately . 2. If a dose of regularly scheduled medication is withheld . the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation . 4. The resident ' s MAR/TAR is initialed by the person administering the medications, in the space provided under the date, and on the line for that specific medication dose administration and time .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145</p> <p>Based on interview and record review, the facility failed to verify accuracy of the prescribed parameters for a blood pressure (BP) medication, for one of seven sampled residents (Resident 2).</p> <p>This failure had the potentially to cause harmful side effects from the blood pressure medication for Resident 2.</p> <p>Findings:</p> <p>On October 21, 2024, at 8:58 a.m., an unannounced visit was made to the facility for a quality-of-care issue.</p> <p>A review of Resident 2's medical records, titled, Face sheet, undated, indicated, resident was admitted to the facility on [DATE], with a diagnosis of hypertension {HTN}-high blood pressure).</p> <p>A review of Resident 2's physician orders, dated September 13, 2024, indicated, . Metoprolol Succinate . 50MG ({Milligrams}-a unit of measure) . (daily) . for HTN hold if sbp ({SBP}-top number of blood pressure) < (below) 110 or Pulse > (above) 60 .</p> <p>A review of Resident 2's Medication Administration Record (MAR), dated September 2024, indicated, Metoprolol was administered outside of the prescribed parameters between September 14 and September 30, 2024.</p> <p>A review of Resident 2 's care plan, dated September 15, 2024, indicated, .Medication-antihypertensives (HTN) .Interventions . (Administer) Medications as ordered. Adhere to parameters . for holding medication as ordered .</p> <p>On October 25, 2024, at 11:00 a.m., a concurrent interview and review of Resident 2 ' s September 2024, MAR were conducted with the LVN. The LVN confirmed Metoprolol had been administered outside of the ordered parameters on 10 out of 17 days, on September 18, 19, 20, 23, 24, 25, 26, 28, 29 and 30, 2024. The LVN stated, the ordered parameters to Hold if Pulse above 60 were incorrect, explaining the order for Metoprolol is usually hold for pulse below 60 and not above. The LVN stated, she should have caught the ordered parameter and corrected it. The LVN further stated, she had to call the physician, verify the order, and then document the clarification in the order and a progress note.</p> <p>On October 25, 2024, at 1235 p.m., a concurrent interview and review of Resident 2 's September 2024 MAR were conducted with the Dirrector of Nursing (DON). The DON stated the parameter for Metoprolol, appears wrong, as the medication normally has parameters to hold if pulse is below 60, not above. The DON stated, when an order, appears wrong, the nurse should call the physician to verify the order, document the correction in the order, and document in the progress note. The DON verified Metoprolol was administered daily outside the ordered parameter of hold if pulse above 60, and the medication should have been withheld, until the nurse verified the parameters.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facilities policy & procedure, dated, January 2024, indicated, .Medications are administered as prescribed in accordance with manufacturers ' specifications, (&) good nursing principles and practices . If a dose seems excessive . or medication order seems to be unrelated to the resident ' s current diagnosis or conditions . the nurse contacts the prescriber for clarification . the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff donned (put on) required Protective Personal Equipment ((PPE)-equipment worn to protect against the spread of infection to self or others) when entering a contact precautions (Precautions for resident known or suspected to be infected with transmissible microbes) isolation room for Resident 1.</p> <p>This failure had the potential to spread harmful microbes (germs) to residents, staff and others within the facility.</p> <p>Findings:</p> <p>On October 21, 2024, at 8:58 a.m. an unannounced visit to the facility was made for a quality-of-care issue.</p> <p>On October 21, 2024, at 11:25 a.m., an observation of Resident 1's room door was made, which indicated, a sign stating resident was on contact precautions, requiring staff to wash their hands, and don PPE of a mask, gloves, and gown before entering Resident 1's room.</p> <p>A review of Resident 1's medical record, titled, Face Sheet, undated, indicated, resident was admitted to the facility on [DATE], with a diagnosis of peritoneal (Tissue that lines the abdominal wall) abscess (pus-filled pocket).</p> <p>A review of Resident 1's physician orders dated October 9, 2024, indicated . isolation with: contact . precautions related to . (infected) abdominal wounds .</p> <p>A review of Resident 1's care plan dated September 20, 2024, indicated .Isolation Precautions: Resident requires contact precautions .Interventions .Use of (PPE) as recommended for type of infection .</p> <p>On October 21, 2024, at 12:05 p.m., an observation of CNA 1, carrying a lunch tray, into Resident 1's room was conducted. It was observed that CNA 1 was wearing a surgical mask, and did not don the required PPE, including gloves and a gown, prior to entering Resident 1's room.</p> <p>On October 21, 2024, at 12:09 p.m., an interview was conducted with CNA 1, who stated, when a resident is on contact precautions, staff are required to don a mask, gown, and gloves prior to entering the resident's room. CNA 1 verified, Resident 1 is on contact precautions, and she entered resident's room without donning the proper PPE. CNA 1 stated, she should have donned the full PPE.</p> <p>On October 21, 2024, at 12:50 p.m., a concurrent observation of CNA 2 collecting Resident 1's lunch tray and interview were conducted. CNA 2 was observed entering Resident 1's room, who is on contact precautions, without wearing a gown. CNA 2 stated, when a resident is on contact precautions, staff should wear a surgical mask, gloves, and gown before entering the resident's room. CNA 2 stated, she did not don a gown prior to entering Resident 1's room, as she was only picking up resident ' s lunch tray, and not providing care or contact with the resident.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 21, 2024, at 4:21 p.m., an interview was conducted with the Infection Prevention (IP) nurse, who stated, the process for staff to serve food trays to resident's on contact precautions, includes staff working in pairs, as one staff member dons PPE (mask, gloves and gown) prior to entering resident's room, then second staff member, hands the food tray to the first staff member, who then delivers to the resident. The IP further stated, the same process is followed when picking up food trays from a resident on contact precautions. The IP nurse further stated the process CNA's 1 and 2 used to deliver and pick-up Resident 1's lunch tray did not align with the facility's policy. The IP nurse stated a mask, gloves, and gown, should always be worn entering the room of a resident on contact precautions, no matter the reason.</p> <p>On October 21, 2024, at 4:27 p.m., an interview was conducted with the Director of Staff Development (DSD), who stated, staff are required to don a mask, gloves, and gown, anytime they enter a room with contact or droplet precautions, even if just to deliver a food tray. The DSD stated staff should work in pairs, when delivering or picking up food trays. The DSD stated, one staff member will don the full PPE inside the resident's room, while the second staff member hands the tray to the first staff member to deliver it to the resident. DSD stated the same process is followed, when picking up the food trays from a contact precaution room. The DSD further stated, the observation of CNA 1 not donning PPE before entering Resident 1's room, and CNA's not working in pairs to deliver and pick-up Resident 1's lunch tray, was not the appropriate process, and not the facility's policy.</p> <p>A review of the facility's policy and procedure, titled, Isolation - Transmission-Based Precautions & Enhanced Barrier Precautions, revised September 2022, indicated, . Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infections; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . Policy Interpretation and Implementation . 2. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected . The three types of transmission-based precautions are contact, droplet and airborne . 4 . Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door . a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE . Contact Precautions 1. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment . 6. The individual on contact precautions is placed in a private room if possible . 7. Staff and visitors wear gloves . 8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed .</p>		