

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  11/08/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48870</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure consistent fingernail care to maintain grooming was provided, for four of four sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4).</p> <p>This failure resulted in poor hand hygiene and had the potential to result in infections and skin injury.</p> <p>Findings:</p> <p>On September 26, 2024, at 7:30 a.m., an unannounced visit was conducted at the facility to investigate one complaint.</p> <p>During an observation on [DATE], at 8:45 a.m., Resident 1 was sitting in bed, with a sheet covering the left arm. Resident 1 had her arm resting on her abdomen with the call light next to her hand. The right arm had limited movement, and no movement of the left arm. The fingernails on the right hand were medium length with uneven edges and discoloration, with dark debris under the fingernails.</p> <p>During an observation on September 26, 2024, at 12:45 p.m., a Certified Nursing Assistant (CNA) was at the bedside feeding Resident 1 lunch. The fingernails were not discolored, but still had some dark debris under them.</p> <p>During a concurrent observation and interview on September 26, 2024, at 2:17 p.m., with Resident 2, Resident 2 was laying in bed with hands folded across the abdomen. The fingernails were medium length and painted with red nail polish which had begun to chip and crack. Resident 2 stated staff paint fingernails and toenails and perform fingernail care. Resident 2 's toenails were painted purple, and the nail polish was chipped and cracked. The toenails were thick and long. Resident 2 stated the toenails have been bothering her, but staff have not helped with the toenails.</p> <p>During a concurrent observation and interview on September 26, 2024, at 2:47 p.m., with Resident 3, Resident 3 was sitting up in bed. The fingernails are long, some have red nail polish, which is chipped and cracked, and some have the polish almost worn off. The toenails are long, and have blue polish on them, which is chipped and cracking. Resident 3 stated the podiatrist (foot doctor) cuts her toenails. She stated staff paint fingernails and toenails and perform fingernail care.</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
---	-------	-----------

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  11/08/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on September 26, 2024, at 3:04 p.m., Resident 4 was lying in bed with arms over the abdomen, watching tv. The fingernails were not discolored, but there was dark debris underneath the nails.</p> <p>During an interview on September 26, 2024, at 3:20 p.m., CNA 2 stated nail care is performed at least twice per week when the resident receives a shower.</p> <p>During an interview on September 26, 2024, at 3:26 p.m., Licensed Vocational Nurse (LVN) 2 stated CNAs perform most of the nail care and explained nail care should be performed by anyone who notices the nails need care. LVN 2 stated there are no set times or days when nail care is performed, it is ongoing care.</p> <p>During an interview on September 26, 2024, at 3:53 p.m., the Director of Staff Development (DSD) stated all residents in the facility are seen by the podiatrist, staff do not cut toenails. The DSD stated staff can perform nail care and can smooth rough edges as needed. The DSD explained that for chipped, cracking nail polish, the facility has nail polish remover wipes and staff have access to those anytime they notice nail polish that is chipped, cracking, or wearing off. When asked what the risks to the resident is with dirty fingernails or cracked and chipping nail polish, the DSD stated the resident is at risk for infection and with rough nails the resident is at risk for skin injury.</p> <p>A review of Resident 1 ' s chart indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included, amyotrophic lateral sclerosis (a progressive disease by gradual degeneration of nerve cells in the spinal cord that control voluntary muscle movement leading to paralysis), and chronic pain syndrome.</p> <p>A review of Resident 1 ' s Care Plan, dated May 23, 2023, indicated a focus of ADL (activities of daily living) self-care deficit, .Assist with daily hygiene, grooming, dressing, oral care and eating as needed .</p> <p>A review of Resident 2's chart indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included, diabetes mellitus type II (disorder of carbohydrate metabolism and insulin production), polyneuropathy (a disorder that damages the peripheral nerves), and muscle weakness.</p> <p>A review of resident 2 ' s Care Plan, dated April 22, 2024, indicated a focus of ADL/Mobility, .Resident at risk for ADL/Mobility decline and requires assistance .</p> <p>A review of Resident 3's chart indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included, Parkinson ' s disease (movement disorder of the nervous system that worsens over time), muscle wasting and atrophy, and reduced mobility.</p> <p>A review of Resident 3 ' s Care Plan, dated July 25, 2023, indicated a focus of ADL self-care deficit, .Assist with daily hygiene, grooming, dressing, oral care, and eating as needed .</p> <p>A review of Resident 4 ' s chart indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included, idiopathic neuropathy (nerve damage with no clear cause), dementia (a progressive decline in cognitive function), and legally blind.</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  11/08/2024
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 4's Care Plan, dated September 6, 2024, indicated a focus of ADL/Mobility, Resident at risk for ADL/Mobility decline and requires assistance .</p> <p>A review of the facility's policy and procedure titled Fingernails/Toenails, Care of, dated February 2018, indicated, .Nail care includes daily cleaning and regular trimming .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .</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  11/08/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48870</p> <p>Based on interview and record review, the facility failed to provide appropriate care and services to prevent urinary tract infection (a bacterial infection that affects the urinary tract, which includes the bladder, uretha, and kidneys) for one of six sampled residents, when:</p> <ol style="list-style-type: none"> <li>1. Foley catheter (flexible tube that drains urine from the bladder into a collection bag) care was not consistently provided in accordance with the care plan.</li> <li>2. Urinary output was not consistently monitored in accordance with the physician order.</li> </ol> <p>These failures could have contributed to the recurrent UTI which led for Resident 5 to be transferred to the general acute care hospital (GACH), where the resident was diagnosed with sepsis.</p> <p>Findings:</p> <p>On September 26, 2024, at 7:30 a.m., an unannounced visit to the facility was conducted to investigate quality care issues.</p> <p>A review of Resident 5's medical record indicated, Resident 5 was admitted to the facility on [DATE], with diagnoses which included benign prostate hyperplasia (BPH-prostate gland enlargement that can cause urination difficulty), urinary tract infection, and self-catheterization (insertion of a flexible, hollow tube into and out of the bladder to drain urine) for [AGE] years.</p> <p>A review of Resident 5's care plan dated August 6, 2024, indicated the following:</p> <ul style="list-style-type: none"> <li>- Focus: Bladder: At risk for complications with urinary system related to indwelling catheter</li> <li>- Goals: Will have no complications or infections r/t (related to) urinary device</li> </ul> <p>-Interventions: Administer medications as ordered. Change Foley catheter per facility policy and physician order. Keep anchored for security and to prevent trauma. Notify physician of signs and symptoms of UTI such as mental status changes, fousl smelling urine, color change in urine, hematuria, sedimentation, burning with urination, increased temperature. Observe for signs of urinary retention such as bladder distention or complaints of lower abdominal pain.</p> <p>A review of Resident 5's Order Summary Report dated August 2024, indicated the following:</p> <ol style="list-style-type: none"> <li>a. Indwelling foley catheter care q (every) shift; ordered on August 2, 2024.</li> <li>b. Monitor output every shift for foley catheter use, ordered on August 2, 2024.</li> </ol> <p>A review of Resident 5's Treatment Administration Record (TAR), for August, did not reflect whether the resident has a foley catheter and did not indicate the justification for a foley catheter use.</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  11/08/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A reiew of Resident 5's medical record titled, TAR, dated August 2024, indicated, .Indwelling Foley catheter care q (every) shift . was not performed on the following dates and shifts:</p> <p>August 6, 2024 - night shift</p> <p>August 8, 2024 - night shift</p> <p>August 9, 2024 - day shift</p> <p>August 10, 2024 - night shift</p> <p>August 12, 2024 - night shift</p> <p>August 13, 2024 - evening shift and night shift</p> <p>August 15, 2024 - evening shift</p> <p>August 17, 2024 - night shift</p> <p>August 18, 2024 - night shift</p> <p>August 24, 2024 - day shift</p> <p>August 25, 2024 - night shift</p> <p>August 27, 2024 - evening shift</p> <p>August 29, 2024 - day shift</p> <p>August 30, 2024 - day shift</p> <p>A review of Resident 5's medical record titled, TAR, dated September 2024, indicated, Indwelling Foley catheter care q shift . was not performed on the following dates and shifts:</p> <p>September 1, 2024 - evening shift</p> <p>September 2, 2024 - day shift and evening shift</p> <p>September 3, 2024 - day shift, evening shift, and night shift</p> <p>September 5, 2024 - day shift, evening shift, and night shift</p> <p>September 6, 2024 - evening shift and night shift</p> <p>September 8, 2024 - evening shift</p> <p>September 9, 2024 - evening shift</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  11/08/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>September 13, 2024 - evening shift</p> <p>September 14, 2024 - evening shift and night shift</p> <p>September 16, 2024 - day shift</p> <p>September 18, 2024 - evening shift</p> <p>A review of Resident 5's TAR for September 2024, indicated monitoring of output was not signed as completed on September 6, 2024 (evening shift); and September 12, 2024, (day and evening shift).</p> <p>During an interview on September 30, 2024, at 1:55 p.m., with LVN 5, LVN 5 stated residents with foley catheter were being assessed for color of the urine, presence of odor, and the presence of sediments in the urine. She stated the Certified Nursing Assistant (CNA) performs catheter care every shift.</p> <p>During a concurrent interview and record review on October 1, 2024, at 1:30 p.m., with the Director of Nursing (DON), the DON stated the Licensed Nurses were supposed to keep track of the daily total of urine output. The DON, the documentation for Foley catheter care for the month of August 2024, and the month of September 2024, was reviewed, and the DON stated that if there was no documentation, this meant the care was not provided. The DON stated the resident is at further risk for complications and infections if foley catheter care was not conducted.</p> <p>During interview on November 8, 2024, at 1:20 p.m., the Director of Staff Development (DSD) stated there should be documentation in the physician order for the justification of Foley catheter use, and she also clarified that foley catheter care is being conducted by licensed nurses and not CNAs.</p> <p>A review of Resident 5's physician orders and progress notes from August 1 to September 19, 2024, indicated the resident had received treatment for UTI, multiple times during the facility admission:</p> <ul style="list-style-type: none"> <li>a. Levaquin Oral tablet 500 mg, one tablet for UTI for three (3) days from August 6 to August 9, 2024.</li> <li>b. Levaquin Oral tablet 500 mg, one tablet for UTI for 10 days from August 27 to September 6, 2024.</li> <li>c. Macrobid Oral capsule 100 mg, 1 capsule two times day for UTI from August 31 to September 10, 2024.</li> </ul> <p>A review of Resident 5's medical record titled Progress Notes, dated September 12, 2024, indicated, Dr. [sic] .was notified patient continues to report urinary discomfort, lower back pain, and is noted to have episodes of confusion .Macrobid completed on 9/10/24 (September 10, 2024) .Order obtained for .UA w/ c+s [sic-urinalysis with culture and sensitivity] if indicated .</p> <p>A review of Resident 5's medical record titled, Lab Results Report, dated September 13, 2024, indicated the urinary tract infection was still present, with more abnormal lab values. The lab documented, .urine culture not indicated .</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  11/08/2024
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 5's medical record titled Progress Notes, dated September 14, 2024, indicated . Resident had decreased urine output .with hematuria (blood in the urine) .MD [sic- medical doctor] made aware .</p> <p>There was no Progress Notes for the dates of September 15 and 16, 2024, to indicate the status of the decreased urine output with hematuria noted on September 14, 2024.</p> <p>A review of Resident 5's medical record titled, Change of Condition Evaluation, dated September 19, 2024, indicated, .Patient noted to not have had urinary output since 9/187/2024 while on continuous hydration . Patient .have abdominal distention and reports pain and increasing pressure. Patient noted to appear SOB [sic-short of breath], lung sounds .diminished .bilaterally, using accessory muscles, urinary catheter dislodged- clogged with purulent (pus) bloody discharge .transfer to ER .</p> <p>A review of the facility policy and procedure titled, Catheter Care, Urinary, revised September 2014, indicated, .Following aseptic insertion of the urinary catheter .Check the resident frequently .Maintain clean technique [hand hygiene and gloves] when handling .the catheter, tubing, or drainage bag .Routine hygiene is appropriate .empty the collection bag at least every eight (8) hours .Observe the resident for complications associated with urinary catheters .Observe for other signs and symptoms of urinary tract infection .</p> <p>A review of the Centers for Disease Control and Prevention (CDC) document titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, updated June 6, 2019, indicated in Summary of Recommendations, .Perform hand hygiene immediately before and after insertion or any manipulation of the device or site .Ensure that only properly trained persons .who know the correct technique of aseptic catheter insertion and maintenance are given this responsibility .use Standard Precautions, including the use of any gloves and gown as appropriate, during any manipulation of the catheter or collecting system .Ensure that healthcare personnel .are given periodic in-service training regarding techniques and procedures for urinary catheter insertion, maintenance, and removal. Provide education about CAUTI (Catheter Associated Urinary Tract Infections) .Consider surveillance for CAUTI when indicated by facility-based risk assessment .</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  11/08/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48870</b></p> <p>Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment in accordance with the facility policy and procedures for one of two residents (Resident 2) reviewed for oxygen treatment.</p> <p>This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and decline in the residents ' health condition.</p> <p>Findings:</p> <p>On September 26, 2024, at 7:30 am, an unannounced visit to the facility was conducted for the investigation of two complaints.</p> <p>During a concurrent observation and interview on September 26, 2024, at 2:17 p.m., in Resident 2 ' s room, Resident 2 had an oxygen concentrator set up next to the bed, oxygen set at three liters per minute (LPM). The humidification bottle was empty, and was completely dry. Resident 2 stated the water bottle on the oxygen machine had been empty since the previous day. Resident 2 said she said she forgot to tell the staff because she has a bad memory.</p> <p>During an interview on September 26, 2024, at 3:20 p.m., Certified Nurse Aide (CNA) 2 stated for residents using oxygen, she checks to make sure the oxygen is flowing and changes the nasal cannula tubing if it falls on the floor, for everything else she would notify the nurse.</p> <p>During an interview on September 26, 2024, at 3:26 p.m., Licensed Vocational Nurse (LVN) 2 stated she checks the oxygen concentrator at the beginning of her shift and changes the humidifier if needed.</p> <p>During an interview on September 26, 2024, at 3:53 p.m., the Director of Staff Development (DSD) stated the CNAs change the oxygen tubing; and the LVNs, Registered Nurses (RNs), or Respiratory Therapist (RT) would change the settings and the humidification bottle. The DSD stated the LVN should be checking the oxygen delivery system every shift to ensure it is working properly.</p> <p>During an interview on September 30, 2024, at 7:30 a.m., the Restorative Nurse Aide (RNA) stated the night shift CNAs would change the oxygen tubing. The RNA stated If there was something wrong with the oxygen concentrator, she would notify the LVN in charge immediately.</p> <p>During an interview on September 30, 2024, at 7:55 a.m., LVN 3 stated the oxygen concentrator is checked every shift by the nurse and the RT would check daily. LVN 3 stated the tubing and humidifier on the oxygen concentrator were changed weekly, every Thursday night. LVN 3 stated the tubing and the humidifier bottle were dated the day it was changed. LVN 3 stated that as needed oxygen orders should be updated as needed, based on the resident ' s condition. LVN 3 did not know if a care plan should be developed for a resident receiving an as needed oxygen.</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  11/08/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on September 30, 2024, at 8:03 a.m., LVN 1 stated she checks the oxygen concentrator every time she enters a resident room because some of the residents would change oxygen settings. She stated the LVNs would change the humidification bottles because they check the oxygen concentrator every shift.</p> <p>A review of Resident 2 's chart indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD, a lung disease causing restricted airflow or breathing problems), anxiety disorder (a disorder caused by excessive anxiety), and atrial fibrillation (an abnormal heart rhythm).</p> <p>A review of Resident 2's Physician's Orders, dated April 19, 2024, indicated .Oxygen at 3 LPM via nasal cannula, every shift for COPD .Monitor vital signs and oxygen levels every shift .</p> <p>A review of Resident 2 ' s Care Plans, dated July 8, 2024, indicated a focus on Respiratory, .goal oxygen saturation will remain above 92% on oxygen .</p> <p>A review of the facility's policy and procedure titled, Oxygen Administration , revised October 2010, indicated, .Review the resident ' s care plan to assess for any special needs of the resident .Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through . periodically re-check water level in humidifying jar .</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  11/08/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48870</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were implemented when multiple staff did not perform hand hygiene during donning (putting on gloves and gown) of PPE (Personal Protective Equipment - mask, gown, gloves, face shield or goggles) and failed to don a face shield or goggles to go inside Droplet Isolation (droplets from coughing, sneezing, or talking may contain viruses or bacteria and generally travel no more than three feet from the patient) rooms when providing care.</p> <p>This failure had the potential to result in the transmission of infection to an already vulnerable population of residents in the facility.</p> <p>Findings:</p> <p>During an observation on September 26, 2024, at 8:22 a.m., a Certified Nurse Assistant (CNA) grabbed a box of gloves from one isolation cart in the hallway and moved it to another isolation cart. The CNA was observed wearing an N95 mask, as she donned a gown and gloves, without performing hand hygiene and the CNA did not put on a face shield or goggles prior to entering a resident's room on Droplet isolation.</p> <p>During an observation on September 26, 2024, at 9:03 a.m., a CNA donned a gown and gloves without performing hand hygiene and the CNA did not wear a face shield or goggles to assist a resident with breakfast.</p> <p>During an observation on September 26, 2024, at 10:00 a.m., an Licensed Vocational Nurse (LVN) and CNA were donning PPE. The CNA did not perform hand hygiene prior to donning a gown and gloves and did not wear a face shield or goggles into the droplet isolation room.</p> <p>During an observation on September 26, 2024, at 10:20 a.m., two CNAs were donning PPE and had supplies to perform incontinence care. The CNAs did not perform hand hygiene prior to donning PPE and did not wear face shield or goggles inside the Droplet isolation room.</p> <p>During an interview on September 26, 2024, at 1:53 p.m., with the Infection Preventionist (IP), the IP stated the last in-service for Covid and PPE use was on September 23, 2024. The IP stated that staff are expected to perform hand hygiene before donning PPE. The IP stated that the staff are expected to wear face shields in Droplet precaution rooms, when staff is providing care to residents and if the employee is in the room longer than 15 minutes, then staff need to change the N95 mask and wear a new mask.</p> <p>On April 27, 2021, at 3:20 p.m., the Director of Staff Development (DSD) was interviewed. The DSD stated the staff should perform hand hygiene before donning and doffing of the isolation gown and gloves. The DSD stated double gloving was not allowed when performing care to the resident.</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  11/08/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility policy and procedure titled, Coronavirus Disease (COVID-19) - Using Personal Protective Equipment, dated May 2023, indicated, .When caring for a resident with suspected or confirmed SARS-CoV-2 infection, personnel who enter the room of the resident will adhere to standard precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection .</p> <p>A review of the facility ' s policy and procedure titled, Handwashing/Hand Hygiene, Revised August 2019, indicated, .Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap .and water for the following situations .Before and after entering isolation precaution settings .</p>		