

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 06/16/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed for two of six sampled residents (Residents 1 and 2) to ensure:</p> <ol style="list-style-type: none"> 1. The call light was placed within reach for Resident 1; and 2. The call light was answered timely for Resident 2. <p>These failures had the potential to compromise the timely delivery of resident care.</p> <p>Findings:</p> <p>On June 10, 2025, at 10:48 a.m., during a concurrent observation and interview with Resident 1 in the resident 's room, Resident 1 was observed to be unable to move her right arm. Resident 1 stated, she was cold and would like a blanket. Resident 1 stated, she could not reach her call light. Resident 1 ' s call light was observed to be placed on the right side of the bed rail, which was in the down position.</p> <p>On June 10, 2025, at 10:54 a.m., during a concurrent observation and interview with Certified Nursing Assistant (CNA) 1 in Resident 1's room, CNA 1 stated, Resident 1 had right-sided weakness and was able to use the call light only if it was placed on the left side. CNA 1 stated, the resident's call light was placed on the right side. CNA 1 stated, the resident would not be able to reach the call light as it was placed on the right side.</p> <p>On June 10, 2025, Resident 1 ' s admission Record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnosed which included cerebral infarction (a type of stroke) with right sided weakness.</p> <p>A review of Resident 1 ' s Care Plan dated September 27, 2024, indicated, .at risk for ADL (Activities of Daily Living)/mobility decline and requires assistance .Encourage to use call light for assistance .</p> <p>On June 27, 2025, at 2:35 p.m., the Director of Staff Development (DSD) was interviewed. The DSD stated, she was familiar with Resident 1. The DSD stated, Resident 1 ' s call light should be placed on the left side, as the resident has right sided weakness. The DSD stated, the resident would not be able to call for assistance if the call light was placed on the right side.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On June 12, 2025, at 12:50 p.m., during a concurrent observation and interview inside Resident 2 ' s room with Resident 2, Resident 2 stated, it took the staff 30 minutes or longer to answer her call lights. Resident 13 was heard yelling for help. Resident 13 ' s call light was observed turned on for about 17 minutes before CNA 2 responded.</p> <p>On June 12, 2025, Resident 2 ' s admission Record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (a type of stroke).</p> <p>A review of Resident 2 ' s care plan dated June 5, 2025, indicated, .ADL/Mobility .Resident .is at risk for ADL/mobility decline requires assistance .Will have needs anticipated and met by staff .Encourage to use call light for assistance .</p> <p>On June 12, 2025, at 1:12 p.m., CNA 2 was interviewed. CNA 2 stated, all staff should respond to call lights and the staff should respond when residents call out or yell for help. CNA 2 stated the call lights should be answered within 15 minutes.</p> <p>On June 27, 2025, at 2:35 p.m., the Director of Staff Development (DSD) was interviewed. The DSD stated, call lights should be answered right away. The DSD stated, if CNAs were not available to respond, other facility staff should answer the call light. The DSD stated, the facility practice is for call lights to be answered within seven minutes.</p> <p>A review of the facility policy and procedures titled, Answering the call light, dated October 2010, indicated, . The purpose of this procedure is to respond to the resident ' s requests and needs .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .Answer the resident ' s call as soon as possible .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the California Department of Public Health within two hours for one of five sampled residents (Resident 1).</p> <p>This failure had the potential to leave Resident 1 unprotected, result in further abuse, and delay the initiation of an investigation.</p> <p>Findings:</p> <p>On June 12, 2025, Resident 1's admission Record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and protein-calorie malnutrition (deficient intake of protein and calories to meet the body ' s energy and tissue-building needs).</p> <p>A further review of Resident 1's HISTORY AND PHYSICAL EXAMINATION, dated September 29, 2024, indicated Resident 1 does not have the capacity to understand and make decisions.</p> <p>A review of Resident 1's SBAR (Situation, Background, Appearance, Review), dated May 17, 2025, indicated, Resident 1 had increased confusion, making allegation of prior abuse.</p> <p>A review of Resident 1's Nurse ' s Note, dated May 17, 2025, at 7 p.m. as documented by Registered Nurse (RN) 1, indicated, .LN [licensed nurse] reported resident alleging sexual assault, patient had made prior claim previously out of confusion .she stated the alleged sexual assault happened 9 months ago .</p> <p>A review of Resident 1's IDT (Interdisciplinary Team) NOTE, dated May 20, 2025, at 10:44 a.m., documented by the Director of Nursing (DON) indicated, .Presented to IDT regarding this behavior of having a rapist roaming around at night .Investigation was made regarding this matter, and resident mentioned this again on 5/17/25, same name presented to the nurse and happened 9 months ago .</p> <p>A review of Resident 1's Behavior Note, dated February 10, 2025, at 1:52 p.m., documented by the DON, indicated, .Visited resident on Saturday around 9:30-10:00 am, interviewed resident regarding her concerns of a person to her ' territory ' .She stated that she thought to tell the staff regarding a guy that has been going to their territory for multiple times .and thought he was roaming around in the facility and touched her .The facility did not have an employee by that name andno [sic] male CNA [Certified Nursing Assistant] assigned to her, and she stated that the nights he was in the facility was not sure, last week, 2 weeks or last night .</p> <p>There was no documentation that the allegation of sexual abuse on May 17, 2025, was reported to the California Department of Public Health within two hours.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On June 27, 2025, at 1:35 p.m., the Director of Nursing (DON) was interviewed. The DON stated, on February 8, 2025, Resident 1 reported she was touched by a man roaming the hallway, however the resident did not provide details and became irritated during the conversation. The DON stated, it was not considered an allegation of abuse so it was not reported. The DON stated, on May 17, 2025, Resident 1 reported being raped multiple times by a man. The DON stated, this incident was not reported to the local state agency or the California Department of Public Health (CDPH) because it was not considered an allegation due to resident's history of confusion and allegations. The DON stated, according to protocol, any allegation of abuse should be reported to CDPH within two hours. The DON stated, in these instances, the facility determined that the reports did not constitute actual allegations and therefore were not reported.</p> <p>On June 27, 2025, at 2:56 p.m., during a concurrent interview and review of Resident 1's SBAR dated May 17, 2025, were conducted with LVN 1. She stated, she documented Resident 1's statements alleging prior abuse, that the resident had been raped in the past. LVN 1 stated, Resident 1's statements were very specific and consistent, but they were interpreted as behavioral in nature rather than an allegation of abuse. LVN 1 stated, she did not report the incident to the CDPH at that time. LVN 1 stated all allegations of abuse should be reported to CDPH within two hours.</p> <p>On June 27, 2025, at 3:12 p.m., during a concurrent interview and review of Resident 1's nurse notes dated May 17, 2025 with the RN, the RN stated, LVN 1 reported to her on May 17, 2025, that the resident had allegedly been sexually assaulted. RN 1 stated, she informed the Administrator and the DON, but the incident was not reported to CDPH. The RN stated, she is a mandated reporter and is required to report any allegation of abuse to CDPH within two hours. RN 1 stated, the incident was not reported because it was not considered an allegation of abuse.</p> <p>A review of the facility policy and procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and investigating, dated September 2022, indicated, .Reporting allegations to the Administrator and Authorities .If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies .the state licensing/certification agency .The local/state ombudsman . ' Immediately ' is defined as .within two hours of an allegation involving abuse .</p>		