

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 07/31/2025
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions for fall prevention were implemented for two of seven residents, (Resident 1 and Resident 7).This failure had the potential for Resident 1 and Resident 7 to fall and sustain serious injuries. Findings:On July 30, 2025, at 11:07 a.m., an unannounced visit to the facility on a complaint investigation was initiated.1.A review of Resident 1's medical records indicated that resident was admitted on [DATE], with diagnoses of systemic lupus erythematosus, (SLE - a chronic autoimmune disease where the body's immune system mistakenly attacks its own healthy tissues and organs), chronic obstructive pulmonary disease, (COPD - a chronic inflammatory disease that causes obstructed airflow from the lungs), 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), dementia, (a chronic or persistent disorder of mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), muscle wasting and atrophy, (the loss of muscle mass and strength), and adult failure to thrive, (AFTT - a syndrome in older adults characterized by weight loss, decreased appetite, poor nutrition, and inactivity indicating a decline in physical and psychological health).A review of Resident 1's History and Physical dated July 17, 2025, indicated resident had intermittent capacity to make decisions.On July 30, 2025, at 12:20 p.m., an interview was conducted with Resident 1. Resident 1 stated she had been at the facility for a month. Resident 1 stated she recalled falling after tripping over her shoes. Resident 1 was unable to account for the date, or time of the incident. Resident 1 stated she did not have any injuries from the fall. Resident 1 stated she gets physical therapy every day and that she had been instructed to use the call light and call for assistance before getting out of bed. On July 30, 2025, at 3:10 p.m., an interview was conducted with Resident 1's Responsible Party, (RP). The RP stated that Resident 1 had been in the facility since March 2025 and had approximately four falls. The RP stated upon admission, he informed them that she was a fall risk. The RP stated in July 2025, Resident 1 slipped out of bed while reaching for her belongings placed on a wheeled table.On July 31, 2025, at 3:31 a.m., an interview was conducted with the Licensed Vocational Nurse, (LVN 1). LVN 1 stated, for all residents who are at high risk for fall, or who have had more than one fall, the interventions should include: bed in low position, call light within reach, all frequently used personal items should be within reach. On July 31, 2025, at 8:20 a.m., an interview was conducted with the Physical Therapist, (PT). The PT stated, on July 24, 2025, Resident 1 slipped out of bed while reaching for the over-bed table. The PT stated, personal items should have been kept within reach to prevent over-reaching and falling out of bed. A review of Resident 1's Care Plan initiated May 7, 2025, indicated Focus. Resident is at risk for falls with or without injury related to altered balance while standing and/or walking, altered mental status, antipsychotic medication, cardiovascular disease, diuretic medication, unsteady gait.Interventions. Keep personal items frequently used within reach.A review of Resident 1's Progress Notes dated July 24, 2025, at 07:25 a.m., indicated Resident was found on the floor on fall mat next to her bed by CNA. Resident was lying on her back on the fall mat. Resident denies hitting her head and denies any pain related to the fall. CNA immediately notified Nurse. RN and Nurse performed a full body assessment, head-to-toe was completed. No skin tears, bruising or visible injuries were noted. Resident was able to move b/l [bilateral] upper extremities without difficulty. Resident reported that she was reaching for her bedside table when she accidentally slipped out of bed. Resident is A/Ox3 [alert and oriented to person, place, and time] cooperative, and denies any pain at this time.2. A review of Resident 7's medical records indicated Resident 7 was admitted to the facility on [DATE], with diagnoses of encounter for surgical aftercare following surgery on the digestive system, malignant neoplasm of colon, (a cancerous tumor that develops in the colon, which is part of the large intestine), secondary malignant neoplasm of liver and intrahepatic bile duct, (cancer that has spread to the liver and bile ducts from a primary cancer site elsewhere in the body), secondary malignant neoplasm of lung, (a cancerous tumor that has spread to the lung from a primary tumor located elsewhere in the body), metabolic encephalopathy, (a problem in the brain caused by a chemical imbalance in the blood), and muscle wasting and atrophy,A review of Resident 7's History and Physical dated June 17, 2025, indicated Resident 7 had the capacity to make decisions.On July 30, 2025, at 12:42 p.m., the Certified Nursing Assistant, (CNA 1) was interviewed. CNA 1 stated that fall-risk residents should always have the call light within reach. On July 31, 2025, at 3:31 a.m., an interview was</p>		