STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555297	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemet Hills Post Acute	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and verify the resident's history of obstructive sleep apnea (OSA - person's breathing repeatedly stops and starts during sleep due to a blocked airway) and coordinate necessary CPAP (Continuous positive airway pressure - a machined use to treat OSA) treatment with the physician, for one of five sampled residents (Resident A).This failure had the potential to result in untreated sleep apnea for Resident A, placing the resident at risk for respiratory complications, hypoxia (low oxygen), and sleep disruption. Findings:On July 7, 2025, at 10:18 a.m., an unannounced visit to the facility was conducted to investigate a quality-of-care issue.On July 7, 2025, at 4:28 p.m., during an interview with Resident A, Resident A stated she had been on CPAP for 20 years and last used it the day before she was admitted to the facility. Resident A stated she was not allowed to use her CPAP machine in the facility. Resident A stated she sleeps almost always in a sitting position and had told the social services and nurses about it.A review of Resident A's record indicated, Resident A was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (a long-term progressive disease that makes it hard to breathe) and atrial fibrillation (irregular heart rhythm).A review of Resident A's hospital records dated May 24, 2024, indicated, .Past medical history .Morbid obesity (extremely overweight), OSA on CPAP .Further review of Resident A's record indicated there was no documentation that a CPAP machine was provided, nor any documentation verifying the resident's continued need for CPAP therapy. On July 10, 2025, at 4:15 p.m., during an interview with the Director of Nursing (DON), the DON stated there was no documented diagnosis of sleep apnea, no care plan addressing sleep apnea, and Resident A was not placed on a CPAP machine. The DON further stated that according to the resident the CPAP machine was broken prior to admission.On July 22, 2025, at 5:50 a.m., during an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she worked the night shift from 10:30 pm to 6:30 a.m. and was familiar with Resident A. LVN 1 stated, she had observed Resident A sleeping at times lying on her side and at other times sitting up in bed. On July 22, 2025, at 8:56 a.m., during a concurrent interview and record review of Resident 1's hospital records dated May 24, 2024, with the MDS Nurse, the MDSN stated during assessment, he reviews a resident's hospital records, including clinical and past medical history. The MDSN stated, Resident A's diagnosis of OSA was missed during the comprehensive assessment. The MDSN stated whoever is involved in the care of the resident should be responsible for the medical history of the resident. The MDSN stated, the diagnoses of sleep apnea should have been verified with the physician to determine if the diagnoses was active and that the resident should have been asked about current CPAP use. The MDSN stated this had the potential to affect the resident's overall respiratory condition.On July 23, 2025, at 2:48 p.m., during an interview with the Assistant Director of Nursing (ADON), the ADON stated if there was a medical history of obstructive sleep apnea, it should have been included in the development of baseline care plan. The ADON stated, the licensed nurses should have contacted the physician to verify the diagnosis and communicated with the resident to verify prior CPAP use. The ADON further stated if the facility was informed that the CPAP machine was broken, the physician should have been notified, and an order for a replacement should have been obtained.A review of the facility's policy and procedures titled CPAP/BiPAP Support, dated March 2015 indicated, .CPAP.to improve arterial oxygen (PaO2) in resident with obstructive sleep apnea.