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	12/16/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to ensure blood glucose meters (glucometer - a blood sugar meter measures the amount of sugar in a small sample of blood) were calibrated and documented according to the facility protocol and current professional standards of practice on multiple days on November 2025. This failure had the potential to result in inaccurate blood glucose readings for residents requiring routine monitoring.Findings:A review of Station Three, Cart C November 2025 Quality Assurance Log indicated missing documentation for the following dates, with blank entries for time, staff performing, machine lot number, test strip lot number, low control, high control, and actions taken: -November 14, 2025;-November 15, 2025; and -November 19, 2025. On December 1, 2025, at 10:52 a.m., an interview and review of Station Three Quality Assurance Log were conducted with the Licensed Vocational Nurse (LVN 1). LVN 1 stated, glucometer calibration was the responsibility of the night shift nurse and was documented on the assurance logs located on the medication carts. LVN 1 stated there were two medication carts per station and stated we are good about doing the checks. LVN 1 further acknowledged the November 2025 log had missing documentation on November 14, 15, and 19, 2025, and there should not be any gaps on the logs. A review of the November 2025 Station One's Cart B Quality Assurance Logs indicated missing documentation on the following dates, with blank entries for time, staff performing, machine lot number, test strip lot number, low control, high control, and actions taken:-November 15, 2025;-November 16, 2025;-November 20, 2025;-November 21, 2025; andNovember 25, 2025 (low and high control and actions taken - blank). On December 1, 2025, at 11:18 a.m., a concurrent interview and record review were conducted with Registered Nurse Supervisor (RNS) at Station one. The RNS stated, LVNs on the night shift was responsible for completing glucometer calibration logs including lot numbers, control ranges and results. The RNS stated the logs were necessary to ensure accurate blood glucose readings. The RNS stated if there is nothing written you would not know if the glucometer was checked and then you would not know if your readings were accurate. The RNS stated the licensed nurses for the day shift should double check the logs during reports and make the corrections. RNS stated she was not previously aware of the gaps. On December 1, 2025, at 12:32 p.m., a concurrent interview and record review was conducted with the Director of Staff Development (DSD). The DSD stated the night shift was responsible for completing the calibration logs and that oncoming shifts should review and complete the logs if missing to ensure accuracy. A review of the November 2025 Quality Assurance Log for Station Two Carts B and C indicated missing documentation as follows, with blank entries for time, staff performing, machine lot number, test strip lot number, low control, high control, and actions taken: -Station Two Cart B - November 19, and 25, 2025-Station Two Cart C - November 29, 2025 On December 1, 2025, at 12:53 p.m. an interview and record review were conducted with the Director of Nursing (DON). The DON stated the LVN's conducting the medication administration for the night shift should be doing the glucometer checks and when the checks are done that were to fill out the assurance log fully including the lot number and range and results. The DON stated the logs were necessary to ensure accurate readings of the blood sugars levels for the residents who need to have their levels checked. The DON confirmed there were four missing gaps for the month of November for Cart B and Cart C. The DON stated she did have a concern that if there is a blank portion of the assurance forms there should be a follow up by the day shift nurse and that day shift nurse should fill out the form as well to confirm that the glucometer check was done. The DON stated that if the forms were not filled out completely there was no way to know if it was done correctly or accurately. The DON stated if the forms are left blank there would be a risk for the residents' blood sugar readings to not accurately reflect the glucose levels. A review of the facility policy titled, Obtaining a Fingerstick Glucose Level dated October 2011, indicated, the purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level.equipment and supplies.Reagent strip with color chart (e.g., Chemstrip) or blood glucose monitoring system (meter with test strips and calibration supplies).follow the instructions provided by the manufacturer of the glucose monitoring system to obtain a blood glucose reading, including the quality control monitoring of the glucometer. documentation.the person performing this procedure should record the following information in the resident's medical record.date and time the procedure was performed.name and title of individual who performed the procedure.all assessment data obtained during the procedure.results.follow facility policies and procedures.A review of the facility policy titled, Nursing Care of the Older Adult with Diabetes Mellitus dated November 2020, indicated , to provide an overview of diabetes in the older adult and the principles of glucose