| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555297 | A. Building<br>B. Wing | 01/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hemet Hills Post Acute | 1717 West Stetson Avenue<br>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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(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 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on interview and record review the facility failed to ensure Levothyroxine was administered for one of one resident (Resident 6) reviewed for quality of care, when Resident 6 did not receive the scheduled dose of Levothyroxine on November 30, 2025 and December 4, 2025.This failure had the potential for Resident 6 not to receive the desired benefit of the medication and may cause adverse reactions.Findings:On December 5, 2025, at 10:44 a.m., an interview was conducted with Resident 6 in her room. Resident 6 stated she did not receive her daily scheduled dose of Levothyroxine on November 30, 2025 and December 4, 2025. A review of Resident 6's admission Record dated December 5, 2025, indicated an admission date of February 6, 2023, with a diagnoses which included hypothyroidism (condition where the thyroid gland does not produce enough essential hormones (like thyroxine) to regulate the body's energy use, slowing down metabolism and bodily functions like heart rate, breathing, and digestion).A review of Resident 6's History and Physical dated October 20, 2025, indicated resident had the capacity to understand and make decisions. A review of Resident 6's Physician Orders dated December 22, 2025, indicated Levothyroxine (thyroid hormone medication to treat hypothyroidism (an underactive thyroid gland)) Sodium Oral Capsule 150 micrograms (mcg - a unit of measurement), give 150 mcg by mouth in the morning for Hypothyroidism was ordered on August 28, 2025.A review of Resident 6's November 2025 Medication Administration Record (MAR) for Levothyroxine 150 mcg dated November 30, 2025, at 6 a.m., indicated the medication was not administered. A review of Resident 6's Medication Administration Note dated November 30, 2025, at 5:36 a. m. indicated, .Levothyroxine Sodium Oral Capsule 150 mcg Give 150 mcg by mouth in the morning for Hypothyroidism waiting on meds to be delivered.A review of Resident 6's December 2025 Medication Administration Record (MAR) for Levothyroxine 150 mcg dated December 4, 2025, at 6 a.m. was blank and did not indicate a checkmark, representing the medication was administered.There was no documented evidence that Levothyroxine was administered on November 30, 2025 and December 4, 2025.A review of the Electronically Transmitted Prescription dated December 4, 2025, indicated Resident 6's Levothyroxine 150 mcg 14 tablets was received and signed by Licensed Vocational Nurse (LVN) 1 on December 4, 2025, at 5:24 a.m.On December 17, 2025, at 4:47 p.m. an interview was conducted with LVN 1. LVN 1 stated Resident 6 missed a dose of Levothyroxine on November 30, 2025 due to not being available. LVN 1 stated she signed the Electronically Transmitted Prescription for Resident 6's Levothyroxine on December 4, 2025 at 5:24 a.m., which indicated Levothyroxine was received and available for administration. LVN 1 stated Resident 6's Levothyroxine was not administered on December 4, 2025, at 6 a.m. and it should have been. LVN further stated it was important to administer the medication to prevent any adverse reactions from a missed dose.On December 19, 2025 at 2:08 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 6 missed Levothyroxine dose on November 30, 2025 and was unsure why when it was administered prior to and after this date. The DON stated Resident 6's Levothyroxine was received and signed by LVN 1 on December 4, 2025 at 5:24 a.m. and was available for administration. The DON stated there was no reason not to administer the medication as it was delivered on time for the scheduled dose and the nurse should have administered the medication. The DON stated there was no documentation indicating the medication was administered. The DON stated it was important to administer the medication to prevent adverse reactions from a missed dose related to her diagnosis of hypothyroidism.A review of the facility policy and procedure titled, Administering Medications, dated April 2019, indicated, . Medications are administered in accordance with prescriber orders. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure, for one of nine resident reviewed for infection control (Resident 8), proper infection control measures were implemented when Certified Nursing Assistant (CNA) 1 did not wear personal protective equipment (PPE - equipment, such as gloves and gown, used to protect against infection or illness) upon entering Resident 8's room, who was on contact isolation precautions (an infection control intervention to reduce transmission of multidrug-resistant organisms (bacteria that have become resistant to multiple antibiotics)).The failure had the potential to result in cross contamination and increasing the spread of infection among a vulnerable population.Findings:On December 5, 2025, at 11:40 a.m., an observation was conducted outside Resident 8's room. A contact isolation sign was posted outside Resident 8's room, along with a PPE cart containing gowns and gloves. The sign indicated, .STAFF MUST.Put on gloves before room entry.Put on gown before room entry.On December 5, 2025, at 11:47 a.m. an observation was conducted inside Resident 8's room. Resident 8 activated his call light. CNA 1 entered the room without a gown or gloves and turned off the call light by pressing the button beside the bed.On December 5, 2025, Resident 8's record was reviewed. Resident 8 was admitted to the facility on [DATE] with diagnoses including extended spectrum beta lactamase (ESBL - bacteria that are resistant to many antibiotics) to the right foot wound. A review of Resident 1's Minimum Data Set (MDS - an assessment tool) dated September 24, 2025, indicated a Brief Interview for Mental Status (BIMS - a tool to assess cognitive function) score of 12 (moderate cognitive impairment). A review of the facility document titled, Order Listing Report, dated December 5, 2025 indicated, .Strict Single Room Isolation with: Contact Precautions due to ESBL.On December 5, 2025, at 2:30 p.m. an interview was conducted with CNA 1. CNA 1 stated Resident 8 was on contact isolation precautions. CNA 1 stated she did not wear a gown or gloves prior to entering Resident 8's room to clear the call light. CNA 1 stated she should have worn a gown and gloves prior to entering Resident 8's room. CNA 1 further stated this was important to prevent the spread of infection.On December 19, 2025, at 11:31 a.m. an interview was conducted with the Infection Preventionist (IP). The IP stated based on the CDC's contact isolation sign and the facility's policy, CNA 1 should have worn a gown and gloves prior to entering Resident 8's room. The IP stated it was important to follow the CDC guidelines and facility policy to protect others from infection or cross contamination.On December 19, 2025, at 2:08 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated it was the best practice to wear a gown and gloves prior to entering a resident's room who was on contact isolation precautions. The DON stated CNA 1 should have followed the facility policy of wearing a gown and gloves prior to entering Resident 8's room. The DON stated it was important to follow the facility's policy to reduce the transmission of infection.A review of the facility policy and procedure titled, Isolation - Categories of Transmission-Based Precautions, dated September 2022 indicated, .Contact Precautions.Staff.wear gloves. when entering the room.Staff.wear a disposable gown upon entering the room. |