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	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemet Hills Post Acute	1717 West Stetson Avenue Hemet, CA 92545

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the plan of care (POC) was updated to reflect changes in condition, for one of two residents reviewed for care planning (Resident 6), who had repeated episodes of pulling out her G-tube (a surgically implanted tube needed for feeding when unable to swallow) from October 11, 2025, to November 12, 2025. This failure had the potential to place the residents at risk for further harm and complications.Findings: A review of Resident 6's medical record was conducted. Resident 6 was admitted to the facility on [DATE] with diagnoses which included, Metabolic encephalopathy (a brain dysfunction caused by a chemical imbalance or metabolic problem in the body.) The Minimum Data Set (MDS - an assessment tool), dated October 25, 2025, indicated a BIMS (Brief Interview of Mental Status) score of 99 (severe cognitive impairment status). A review of Resident 6's progress notes from October 10, 2025, to November 30, 2025, indicated Resident 6 pulled out her G-tube on: -October 10, 2025-October 13, 2025-October 21, 2025-October 29, 2025-November 12, 2025; and-November 13, 2025.Each episodes required transfer to the emergency room for G-tube replacement. A review of Resident 6's care plan dated October 2, 2025, October 10, 2025, October 13, 2025, and November 12, 2025, indicated: - The resident was identified being at risk for behaviors related to dementia and for G-tube dislodgement. Interventions included use of an abdominal binder, and monitoring of behaviors. -There were no care plan revisions after the October 21, 2025, episode and the resident continued to experience G-tube dislodgements. -The October 13, 2025, interventions were not reflected in the care plan until after the October 29, 2025, episode. -The care plan-initiated November 12, 2025, listed no new interventions. The care plan did not reflect changes in condition or effectiveness of interventions for each episode. On December 31, 2025, at 12:15 p.m. an interview was conducted with Licensed Vocational Nurse (LVN 4). LVN 4 stated he was assigned to Resident 6 and that he was familiar with her care needs. LVN 4 stated he was not aware of any behaviors related to Resident 6 pulling out her G-tube. On December 31, 2025, at 12:20 p.m. an interview was conducted with Certified Nursing Assistant (CNA 3). CNA 3 stated she was assigned to Resident 6. CNA 3 stated she was not aware of any behaviors related to the resident pulling out her G-tube. On December 31, 2025, at 2:18 p.m. a concurrent interview and record review was conducted with the Registered Nurse (RN 3). RN 3 stated Resident 6 had repeated G-tube pulling behaviors beginning October 10, 2025. RN 3 stated a new intervention was not implemented until November 13, 2025, after multiple episodes. On December 31, 2025, at 3:25 p.m., an interview was conducted with LVN 1. LVN 1 stated the care plan should be updated each time the resident pulled out the G-tube and confirmed there were no revisions after October 21, 2025. On December 31, 2025, at 4:27 p.m. a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the protocols for changes in condition would include an evaluation of the incidents during the interdisciplinary team conferences (IDT) and revisions to the care plans would be made at that time. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated care plans should be revised with each change in condition. The DON stated there were only two IDT review despite six incidents. A review of the facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated March 2022, indicated, .The interdisciplinary tea (IDT), in conjunction with the resident and his/her family or legal representative, develop and implements a comprehensive, person centered care plan for each resident.the comprehensive care plan reflects currently recognized standards of practice for problem areas and conditions.care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers.assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change.the (IDT) reviews and updates the care plan.when there has been a significant change in the resident's condition.when the desired outcome is not met.when the resident has been readmitted to the facility from a hospital stay.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, for one of three residents reviewed for quality of care (Resident 3) the resident was monitored every shift for a change in condition involving left upper extremity bruising (skin discoloration) as ordered by the physician.This failure had the potential to result in a delay of the implementation of appropriate interventions to address the care and treatment for Resident 3. In addition, this failure had the potential to place Resident 3 at risk for injuries. Findings:On December 30, 2025, Resident 3's record was reviewed. Resident 3 was admitted to the facility on [DATE], with diagnoses which included, lack of coordination (poor balance), and iron deficiency anemia (blood doesn't have enough healthy red blood cells). The Minimum Data Set (MDS - an assessment tool), dated September 23, 2025, indicated a BIMS (Brief Interview of Mental Status) score of 10 (moderate cognitive impairment status). A review of the change in condition dated December 16, 2025, at 11:19 p.m. indicated .At approximately 8:58 p.m. Visiting son approached nurses station and reported to LN (licensed nurse) that patient had discoloration to her left forearm along with a skin tear that is closed and dry. LN and RN (Registered Nurse) assessed patient.When asked what happened to her arm she stated: 'all I know is that there was no bruise, then she grabbed me, and then there was a bruise'.physician recommendation.continue to monitor.A review of the Medication Administration Report (MAR) dated December of 2025, indicated the following: .ANTICOAGULANT MEDICATION.MONITOR FOR.BRUISING.Document: Y if monitored and none of the above observed. N if monitored and any of the above was observed.Further review of Resident 3's MAR for the month of December 2025, indicated the following:-December 9, 2025, to December 12, 2025, the licensed nurse did not document a Y or N response and documented - -December 14, 2025, to December 17, 2025, the licensed nurse did not document a Y or N response and documented - A review of Resident 3's Order Summary Report, for the month of December 2025, indicated, .Discoloration to left upper extremity - Monitor for changes in size, location, and appearance. Notify MD (physician) if changes are noted .A review of the Treatment Administration Report (TAR) dated December of 2025, indicated .Discoloration to left upper extremity - Monitor for changes in size, location and appearance. Notify MD if changes are noted. Every shift for left upper extremity.Further review of Resident 3's TAR for December 2025, indicated there was no documentation Resident 3 was monitored for changes in to left upper extremity discoloration on the following dates:-December 19, 2025 (night shift)-December 21, 2025 (afternoon and night shift)-December 22 to December 25, 2205 (night shift)-December 30, 2025 (morning shift)-December 31, 2025 (morning, afternoon, and night shift)A review of the Daily Skilled Charting was conducted from December 15, 2025, to December 24, 2025, indicated there was no additional notes describing Resident 3's skin condition and from December 16, 2025, to December 20, 2025, approximately four days after the allegations of a new left bruise was identified there was no documented evidence the presence of a bruise to the left upper extremity was assessed by the licensed nurses.A review of the Weekly Nursing Summary from December 16, 2025, to December 23, 2025, showed no documented observation, assessment, or monitoring of a new upper left arm bruise. On December 16, 2025, a new upper left arm bruise was identified, and the weekly summaries documented no skin changes or breakdown.A review of the Care Plan titled Resident has skin discoloration on their left forearm, initiated December 16, 2025, indicated, .No emotional; distress, no crying and no report of anyone hurt or hurting her. The resident will not show s/s of emotional distress or any indication of any adverse effect of the allegation daily until next review date.Complete body check of the resident, notification of MD and family.Monitor for emotional distress, fearfulness, check the area of the skin discoloration, any further symptoms, refer to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MD accordingly.Monitor resident's possible adverse effect of the allegation x 72 hours and accordingly.On December 30, 2025, at 3:16 p.m. a concurrent interview and record review was conducted with the Registered Nursing (RN 1). RN 1 stated, any discoloration or bruise identified on a resident's skin requires an internal investigation, physician notification, care plan update, and documentation on the MAR, TAR, progress notes, and daily charting. RN 1 stated, Resident 3 should have been monitored every shift per physician orders and facility protocol.On December 30, 2025, at 4:14 p.m. a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated licensed nurses were expected to monitor skin conditions every shift when a change in condition was identified. The DON stated consistent monitoring was necessary to prevent delays in identifying worsening conditions requiring physician intervention.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident's medical records were accurate and complete in accordance with the accepted professional standards and practices, for two of three sampled residents (Residents 3 and 5) when: 1. For Resident 3, nursing weekly summaries and skin evaluations did not reflect changes in skin condition; and 2. For Resident 5, progress notes regarding the resident's status were not completed in accordance with facility protocols. These failures could negatively impact resident care and prevent staff and responsible parties from recognizing potential deterioration in residents' conditions. Findings:1.On December 30, 2025, Resident 3's record was reviewed. Resident 3 was admitted to the facility on [DATE], with diagnoses including lack of coordination (poor balance), and iron deficiency anemia (blood doesn't have enough healthy red blood cells). Resident 3's Minimum Data Set (an assessment tool), dated September 23, 2025, indicated a BIMS (Brief Interview of Mental Status) score of 10 (moderate cognitive impairment status). A review of Resident 3's change in condition dated December 16, 2025, at 11:19 p.m. indicated .At approximately 8:58 p.m. Visiting son approached nurses station and reported to LN (licensed nurse) that patient had discoloration to her left forearm along with a skin tear that is closed and dry . A review of the Care Plan titled Resident has skin discoloration on their left forearm, initiated December 16, 2025, indicated, .No emotional; distress, no crying and no report of anyone hurt or hurting her. The resident will not show s/s of emotional distress or any indication of any adverse effect of the allegation daily until next review date.Complete body check of the resident, notification of MD and family.Monitor for emotional distress, fearfulness, check the area of the skin discoloration, any further symptoms, refer to MD accordingly.Monitor resident's possible adverse effect of the allegation x 72 hours and accordingly. A review of Resident 3's progress notes dated December 17, 2025, at 2:29 p.m., indicated, .Presented to IDT members regarding resident was noted to have skin discoloration on her left forearm .Monitor the discolorations on her skin for skin breakdown and refer to MD for treatment as needed . A review of the Order summary report dated December 17, 2025, indicated, .Discoloration to left upper extremity - Monitor for changes in size, location and appearance. Notify MD if changes are noted. every shift for left upper extremity. A review of the Medication Administration Report (MAR) dated December of 2025, indicated incomplete documentation related to anticoagulant monitoring: -December 9 to 12, 2025: No Y or N documented -December 13, 2025: N documented without supporting notes -December 14-17, 2025: No Y or N documented A review of the Treatment Administration Report (TAR) dated December of 2025, indicated inconsistent monitoring documentation: -December 17 to 19, 2025: Day and Evening shifts documented; night shift missing on December 19, 2025. -December 20 to 21, 2025: Day shift documented -December 21 to 24, 2025: Evening and night shifts undocumented. A review of the Daily Skilled Charting indicated from December 15 to 24, 2205, licensed nurses documented skin normal without describing the left forearm discoloration. A review of the Weekly Nursing Summary from December 16 to December 23, 2025, indicated there was no documented observations of a new skin change to the upper left arm bruise for a resident with a new bruise. The Weekly Nursing Summaries did not reflect the resident's skin condition. On December 30, 2025, at 3:16 p.m. a concurrent interview and record review was conducted with the Registered Nursing (RN 1). RN 1 stated the daily skilled monitoring and weekly skilled charting should reflect the skin condition and identify any changes in condition so that any changes could be identified and reported. RN 1 stated the monitoring for bleeding was documented as Yes when signs are present and No when no signs are observed. RN 1 stated a Yes indicated a bruise or sign of bleeding was observed but (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	does not specify the location, which is why detailed notes under the skin assessment are important. RN 1 stated no notes were documented from December 18 to December 22, 2205, and documentation should have been present. RN 1 stated licensed nurses were expected to chart the skin condition to show that it was being monitored, according to the physician orders and so that any changes in size, location, or signs of infection could be noted and the physician notified. On December 30, 2025, at 4:14 p.m. a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated that skin changes should have been documented in progress notes, MAR, TAR, daily charting, and weekly summaries. The DON stated that documentation should have reflected the resident's skin condition and any changes. The DON stated that licensed nurse's documentation did not consistently or accurately reflect the Resident 3's skin condition. The DON stated the weekly summary was a recap of the condition of the resident and it should have reflected any changes occurring during the review period and the daily skilled charting should have reflected the conditions of the skin to show improvement or decline and the current condition. The DON stated her expectation was that the nurses should have charted accurate assessments in daily and weekly charting and incomplete documentation would not be reflecting accurately the resident's condition. The DON further stated that skin conditions should have been documented accurately so that the ongoing assessments for the resident's skin conditions could have been communicated with the physician, family, and nursing staff. 2. A review of Resident 5's medical record was conducted. Resident 5 was admitted to the facility on [DATE], with a diagnosis which included, Multiple fractures of ribs, left side, subsequent encounter for routine healing and discharged on December 14, 2025. Resident 5's History and Physical Examination, dated December 14, 2025, indicated Resident 5 had the capacity to understand and make decisions. A review of Resident 5's progress notes from December 13 to December 14, 2025, indicated the following: -December 13, 2025, at 7:12 p.m., indicated, Resident 5, a [AGE] year old m ale, was admitted from an acute hospital with multiple rib fractures (broken bone) and pain to the left ribs and abdomen. Resident 5 was on bed rest receiving oxygen via nasal cannula (a small flexible plastic tube into the nostrils to deliver supplemental oxygen), alert and oriented, with stable respiratory status. Skin assessment revealed tenderness over the left chest wall, partial nail avulsion (an injury in which tissue is forcibly torn away from the body) to the left finger, abrasions (a scrape on the skin) to the left ankle and elbow, and a scab to the left knee. Further review of Resident 5's progress notes from December 13, 2025, at 11 p.m., through December 14, 2025, at 8 a.m., indicated there was no documented evidence regarding the resident's status or condition. -December 14, 2025, 8:58 a.m., indicated, .Patient resting on bed comfortably alert and oriented x 4, Patient is compliant to medication and treatment no complaints of SOB, breathing is even and unlabored. Medication well tolerated. -December 14, 2025, 1 p.m., indicated, .Approximately 1230 therapies notify writer to assess pt (patient) due to SOB, during therapy session. Upon assessment, pt noted to be in respiratory distress with increased work or breathing. Skin observed to be sweaty and cool. Patient oxygen sat decrease to 78% on NC, oxygen applied via non rebreather mask with immediate intervention that went to 87%. Pt stated that the stated its working that his getting air now. vitals sign assessed with BP (blood pressure)117/78. Called 911 to send out patient to hospital for further evaluation and management. Pt monitored continuously until EMS arrival . Approximately 1245 911 paramedics and patient leave the facility. MD and daughter made aware regarding the change of condition and the transfer. On December 31, 2025, at 1:20 p.m., a concurrent interview and record review were conducted with RN 2. RN 2 stated that facility protocol requires nurses to complete progress notes to document each resident's status during every shift. RN 2 stated the admission note was completed during the evening shift and the night (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift progress note was missing and should have been documented. RN 2 stated progress were necessary to establish a baseline and communicate the resident's condition between shifts. On December 31, 2025, at 2:46 p.m. a concurrent interview and record review were conducted with LVN 2. LVN 2 stated the admission occurred during the evening shift and that a progress note should have been completed by the night shift to document the resident's status. LVN 2 stated there was no documentation of Resident 5's status during the night shift. On December 31, 2025, at 4:14 p.m., a concurrent interview and record review were conducted with the DON. The DON stated all new admissions were required to have progress notes for the first 72 hours to reflect the resident's condition. The DON stated the MAR reflected medication administration but did not describe the resident's condition. The DON stated that a night shift progress notes for Resident 5 was missing and that nurses were expected to document the resident's status in the electronic medical record each shift. A review of the facility policy titled, Charting and Documentation dated December 2022, indicated, .the service provided to the resident progress toward the care plan goals.any notable changes in the resident's medical, physical, functional, or psychosocial condition observed by staff, should be documented in the resident's medical record.changes in the residents' condition.entries included should be made by licensed personnel (e.g. RN, LVN).the assessment data and or any unusual findings obtained during the procedure/treatment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented, when an outside vendor ultrasound technician (UT) was observed providing care at the bedside to a resident on contact precautions (infection prevention precautions) without wearing appropriate PPE (personal protective Equipment - a gown and mask) according to the facility protocol. This failure had the potential to result in transmission of infectious illnesses to the vulnerable residents.Findings: On December 31, 2025, at 12:09 p.m., a sign posted outside the room indicated Contact Precautions, requiring staff and visitors to wear a gown, gloves, and mask prior to entering the room and to perform hand hygiene upon entry and exit. An outside vendor UT was observed at the bedside of Resident 6's room. The UT was using an ultrasound machine with the probe touching the resident's arm. The UT was wearing gloves and was not observed to be wearing a gown or mask. The outside vendor UT remained in the room for approximately five minutes. The outside vendor UT re-entered the room without performing hand hygiene or donning new gloves. On December 31, 2025, a review of Resident 6's records were conducted. Resident 6 was admitted to the facility on [DATE], with diagnosis including metabolic encephalopathy (a chemical imbalance of metabolic system which affects the brain). The Minimum Data Set (MDS - an assessment tool), dated October 25, 2025, indicated a BIMS (Brief Interview of Mental Status) score of one (severely impaired cognitive status). A review of Resident 6's physician order dated December 29, 2025, indicated, .contact precautions. On December 31, 2025, at 12:15 p.m., an interview was conducted with Licensed Vocational Nurse LVN. LVN 4 stated Resident 6 was on contact precautions and stated all staff and visitors were required to follow posted PPE instructions. LVN 4 stated the outside vendor UT should have been instructed on PPE requirements prior to entering the room. On December 31, 2025, at 12:20 p.m., an interview was conducted with the Certified Nursing Assistant CNA 3. CNA 3 stated Resident 6 was on contact precautions, and the protocol required gown, gloves, mask, and hand hygiene. On December 31, 2025, at 12:35 p.m., an interview was conducted with the Infection Preventionist LVN 5. LVN 5 stated the outside vendor UT should have followed the required PPE protocols and staff should make sure outside vendors comply with infection prevention measures prior to providing care. On December 31, 2025, 5:15 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated the outside vendor UT should wear the required PPE. The DON stated not wearing the required PPE placed the resident at risk and all individuals entering precaution rooms must follow posted infection control instructions. A review of the policy and procedure titled Initiating Transmission-Based Precautions, dated August 2019, indicated, .Transmission based precautions.when a resident is at risk of transmitting the infection to other residents.when transmission-based precautions are implemented.the signage informs the staff of the type of CDC precautions(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room.signs ensures that protective equipment.(gloves, gowns, masks, etc.) is maintained outside the residents room so that anyone entering the room can apply the appropriate equipment.