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	07/01/2026

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 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 observation, interview, and record review, the facility failed to reassess and revise the resident's person-centered care plan to include effective interventions after repeated incidents of inappropriate sexualized behavior for one of four residents (Resident 1). This failure placed residents, staff, and visitors at risk for unwanted sexual contact, physical altercations, and psychosocial harm. Findings: A review of Resident 1's medical records indicated the resident was admitted on [DATE], with diagnoses which included epilepsy, (a disorder which causes repeated seizures [sudden changes in the brain activity which can cause shaking, confusion, or loss of consciousness) and dementia, (a condition that affects memory, thinking, and judgment). A review of Resident 1's History and Physical dated February 4, 2026, indicated the resident was unable to answer questions. A review of Resident 1's Progress Notes indicated the following: -Dated February 25, 2026, at 2:58 p.m., At approximately 1149, this writer was notified by another resident, this resident allegedly grabbed the resident's butt. per resident, he does not remember the incident. -Dated March 29, 2026, at 4:52 a.m., Loud voices heard in the hall, at approximately 0415. CNA noted pt [patient] attempting to grab the bilateral buttock of CNA that was bending over in the hall. Pt redirected by CNA present. Pt very upset that CNA was attempting to tell him that the action was inappropriate, telling her to mind her own business. This staff attempted to talk to pt to inform him the inappropriateness of this action, however pt refused to believe that what he tried to do was wrong. Pt redirected back to his room, however (sic) took several moments before this happened as pt was attempting to see of (sic) other pts or staff were going to make comments regarding his behaviors. No other person addressed pt, pt then retired back to his room. Will continue to monitor pt and pt behaviors very closely. -Dated May 21, 2026, at 1:35 p.m., .This afternoon noted approximately 1:02 PM by the licensed nurse going through the hallway, however, there was a male visitor standing and talkingto (sic) the RN supervisor at the counter of nurses' station, suddenly turned his back and confronted the resident behind him and allegedly stated that this resident 'touched his butt' . A review of Resident 1's Care Plan indicated the following: -Dated February 25, 2026, Focus. Resident was allegedly accused of having inappropriate touch behavior towards alert, oriented female resident. Allegedly stated she was grabbed on her buttock. Interventions . 1:1 x 72 hours starting 2/25/26.Goals: Resident will not have episodes of inappropriate behavior towards resident daily until next review date. -Dated May 21, 2026, indicated Focus. Resident was allegedly held on his neck by a male visitor with his 2 hands, stated that resident allegedly touched his butt. Further review of Resident 1's record indicated the resident demonstrated repeated inappropriate sexual behaviors toward residents, staff, and visitors which included sexually inappropriate comments and grabbing the buttocks. The facility did not revise the resident's care plan to include additional interventions to reduce the risk of further inappropriate contact. On May 29, 2026, at 12:18 p.m., an interview was conducted with CNA 2. CNA 2 stated that when she was putting a breakfast tray into cart, Resident 1 came up behind her stating I was going to smack your cheeks. CNA 2 stated she did not report the incident to anyone. On May 29, 2026, at 12:28 p.m., an interview was conducted with the visitor. The visitor stated that Resident 1 was in his (continued on next page)

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	wheelchair and grabbed his buttock when he was rolling past. On May 29, 2026, at 5:08 p.m., an interview was conducted with the DON. The DON stated that following Resident 1's March 29, 2026, incident of grabbing a CNA's buttocks, the resident should have been monitored for inappropriate behavior, and the care plan should have been updated to address the resident's behaviors. A review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered revised 2001, indicated .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 9. 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 .When possible, 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 residents' conditions change.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the environment free of accident hazards when the toilet seat in a resident-accessible restroom was not securely fastened.This failure had the potential to cause a resident to lose balance while transferring on or off the toilet, placing the resident at risk for a fall with injury. Findings:On July 1, 2026, at 10:44 a.m., an unannounced visit to the facility was conducted to investigate a physical environment issue. On July 1, 2026, at 12:34 p.m., an observation was conducted in resident accessible restroom [ROOM NUMBER], located across from the Activity Room. The toilet seat was observed to be loose due to a broken mounting bolt on the right side. On July 1, 2026, at 12:55 p.m., an observation and interview were conducted with the Maintenance Staff (MS). The MS inspected the toilet seat and stated that the right-side mounting bolt was broken, causing the toilet seat to be loose. The MS stated that the toilet seat mounting bolt would need to be replaced. A review of the facility's policy and procedure titled Quality of Life - Homelike Environment revised May 2017, indicated .Residents are provided with a safe, clean, comfortable and homelike environment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food stored in the Unit 1 refrigerator was properly labeled, dated, and discarded when no longer safe for use. This failure had the potential to increase the risk of foodborne illness.Findings: On July 1, 2026, at 2:45 p.m., a concurrent observation and interview were conducted with the Licensed Vocational Nurse (LVN 2). In the Unit 1 refrigerator, on the first door shelf, an uncovered container of chicken or tuna salad was observed without a label or date. On the first shelf, a Yoplait Raspberry yogurt with a use-by date of June 23, 2026, was also observed available for consumption. LVN 2 stated that all staff assigned to the unit are responsible for ensuring that food in the refrigerator is covered, labeled, and dated. LVN 2 confirmed that the unlabeled and undated chicken or tuna salad should have been discarded or properly labeled before storage and should not have been available for consumption. LVN 2 further stated that the yogurt with a use-by date of June 23, 2026, should have been discarded and should not have been available for consumption. A review of the facility's policy and procedure titled Labeling and Dating of Foods revised 2023, indicated All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by the date that follows the various storage guidelines within this section-specifically (sic). Refrigerated Storage Guidelines (page 6.16).All prepared foods need to be covered, labeled, and dated.

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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 prevention protocols were followed when a nebulizer treatment mask (a medical accessory that fits over the nose and mouth, delivering aerosolized liquid medication directly into the airways and lungs) was stored uncovered on top of the nebulizer (a medical device that converts liquid medication into a fine mist, allowing patients to inhale it directly into their lungs), for one of eleven residents, (Resident 12). This failure had the potential to expose the nebulizer mask to environmental contaminants before its next use, increasing the risk of introducing microorganisms into the resident's respiratory tract.Findings: A review of Resident 12's medical records indicated resident was admitted on [DATE], with diagnoses of encephalopathy, (any diffuse disease of the brain that alters brain function or structure), chronic obstructive pulmonary disease, (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), heart failure, and functional quadriplegia (the inability to use both arms and both legs due to severe physical weakness or another medical condition.) A review of Resident 12's History and Physical dated April 12, 2026, indicated resident had capacity to make decisions. A review of Resident 12's Order Summary Report dated March 28, 2026, indicated .Ipratropium-Albuterol Solution [a bronchodilator combination used in a nebulizer to open air passages] 0.5-2.5 (3) MG [milligram]/3ML [milliliter] 3ml inhale orally every 8 hours for SOB [shortness of breath]/Wheezing. On June 3, 2026, at 1:39 p.m., an observation was conducted in Resident 12's room. Resident 12 was observed in bed with the nebulizer treatment mask was resting uncovered on top of the nebulizer machine without a protective plastic bag or other covering. On June 3, 2026, at 3:59 p.m., a concurrent observation and interview was conducted with the Licensed Vocational Nurse, (LVN 1). LVN 1 observed Resident 12's bedside table with the nebulizer mask on top of the nebulizer machine. LVN 1 stated the nebulizer mask should have been stored in a plastic bag between treatments to keep it clean and prevent contamination. A review of the facility's policy and procedure titled Departmental (Respiratory Therapy) -Prevention of Infection revised November 2011, indicated .Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol. 7. Store the circuit in plastic bag, marked with date and resident's name, between uses.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eleven residents, (Resident 12), had a call light pad. This failure had the potential for Resident 12 to have unmet needs due to difficulty with using the call light. Findings: On June 2, 2026, at 2:46 p.m., an interview was conducted with the Registered Nurse, (RN 1). RN 1 stated that she had cared for Resident 12 in the past and recalled that Resident 12 used a call light pad and would ask staff to ensure it was functioning. On June 3, 2026, at 1:39 p.m., a concurrent observation and interview were conducted with Resident 12. Resident 12 stated that prior to the most recent hospitalization, he had a call light pad button that was easier to use. Resident 12 demonstrated that using the standard call light button was difficult because his fingers were stiff and difficult to straighten due to curling towards the palm of his hand. Resident 12 was observed holding the standard call light button in his left hand and using the knuckle of his right index finger to depress the button to call for assistance. A review of Resident 12's admission Sheet indicated Resident 12 was initially admitted to the facility on [DATE], with diagnoses which included functional quadriplegia (the person cannot move or use all four extremities effectively). Resident 12 was readmitted on [DATE], following hospitalization and was transferred to a different room. The resident's new room was equipped with standard call light button and not the adaptive call light pad previously used. A review of Resident 12's Progress Notes dated February 2, 2026, at 3 p.m., indicated .Calling pad within reach. On June 3, 2026, at 2:37 p.m., an observation was conducted with the Maintenance Staff (MS), the MS was observed disconnecting the regular call light button from the wall and connecting a call light pad to the wall on the right side of Resident 12's bed. A review of the facility's policy and procedure titled Call System, Residents revised September 2022, indicated .If the resident has a disability that prevents him/her from making use of the call system, an alternative communication that is usable for the resident is provided and documented in the care plan.