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	01/17/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on interview and record review, the facility failed to provide Advance Directive (AD-a written instruction related to the provision of health care when the resident is no longer able to make decisions) education, materials, and follow-up for two of three residents reviewed for AD (Residents 73 and 130) and/or their resident representatives (RP). This failure had the potential in Residents 73 and 130's medical preferences not being honored during critical healthcare decisions. Findings: 1. A review of Resident 73's Admission Record, indicated Resident 73 was admitted to the facility on [DATE]. A review of Resident 73's History and Physical dated May 25, 2024, indicated Resident 73 had the capacity to understand and make decisions. A review of Resident 73's Advance Directive Acknowledgement Form, dated May 26, 2024, indicated Resident 73 has not executed an AD. A review of Resident 73's Social History Review (Quarterly), dated December 6, 2024, indicated, . Self-responsible .Advance Directive .None of the above . A review of Resident 73's IDT Conference Summary, dated December 10, 2024, indicated the formulation of AD was not discussed with Resident 73 or the RP. Further review of Resident 73's medical record indicated no documented evidence Resident 73 and or the RP was provided education and information about AD. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 17, 2025, at 8:42 a.m., during a concurrent interview and review of Resident 73's medical record with the Social Service Director (SSD), she stated if a resident did not have an AD, she would offer resources and education to the resident or RP. The SSD further stated it was important for residents to be educated and have the opportunity to formulate an AD in the event the resident were unable to make decisions in the future. The SSD stated Resident 73 had no AD, was not provided education, and was not reviewed for AD. The SSD further stated she should have followed up and provided AD education to Resident 73 or the RP. 2. A review of Resident 130's Admission Record, indicated Resident 130 was admitted to the facility on [DATE]. A review of Resident 130's History and Physical dated May 25, 2024, indicated Resident 130 had the capacity to understand and make decisions. A review of Resident 130's Advance Directive Acknowledgement Form, dated May 23, 2024, indicated Resident 130 has not executed an AD. A review of Resident 130's IDT Conference Summary, dated December 4, 2024, indicated .Informed resident on advance health care directive .Resident interested in completing form . A review of Resident 130's Social History Review (Quarterly), dated December 6, 2024, indicated the formulation of AD was not discussed with Resident 130 or the RP. Further review of Resident 130's medical record indicated no documented evidence Resident 130 was assisted and provided information about the formulation of an AD. On January 17, 2025, at 9 a.m., during a concurrent interview and review of Resident 130's medical record with the SSD, she stated Resident 130 had expressed interest in the formulation of an AD and was not assisted or provided materials to formulate an AD. The SSD further stated she should have followed up, assisted, and provided materials to Resident 130 or the RP. A review of the facility policy and procedure titled, Advance Directives, dated 2016, indicated, .Social service director or designee will inquires of the resident .about the existence of any written advance directive .If a resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives .Staff will document in the medical record the offer to assist and the resident decision to accept of decline assistance .

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309 Based on interview and record review, the facility failed to ensure the annual comprehensive assessment for two of 27 residents reviewed for resident assessment (Residents 70 and 85) were completed within 14 calendar days, as required by the Center for Medicare and Medicaid Services (CMS - an agency that administers the nation's major healthcare programs). This failure had the potential for Residents 70 and 85 to not receive resident centered care (care focusing on the needs of individuals). Findings: 1a. A review of Resident 70's Minimum Data Set (MDS - an assessment tool) annual assessment dated [DATE], indicated the assessment was completed on January 11, 2025, 37 days after the assessment reference date (the final day of observation period during which the resident's status is assessed and documented). 1b. A review of Resident 85's Minimum Data Set annual assessment dated [DATE], indicated the assessment was completed on January 11, 2025, 35 days after the assessment reference date. On January 17, 2025, at 11:26 a.m. a concurrent interview and record review was conducted with the MDS Coordinator (MDSC). The MDSC stated the annual comprehensive assessments for both Residents 70 and 85 were completed late on January 11, 2025. The MDSC further stated it was important for annual comprehensive assessments to be completed and transmitted to CMS in a timely manner to ensure assessments and plan of care were accurate for the residents. On January 17, 2025, at 4:02 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the annual comprehensive assessments for Residents 70 and 85 should have been completed within 14 days to ensure accurate assessments and provide the residents centered care plans. The DON further stated the MDSC should have completed and submitted the annual assessment in a timely manner. A review of the facility document titled, RAI OBRA-required Assessment Summary dated October 2024, indicated, Assessment Type: Annual (Comprehensive) .MDS Completion Date (item Z0500B .No Later Than . ARD +14 calendar days . A review of the facility policy and procedure title, MDS Completion and Submission Timeframes, dated July 2017, indicated, .The assessment coordinator or designee is responsible for .resident assessments . submitted to CMS .in accordance with current federal and state guidelines .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident’s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) quarterly assessments were completed within 14 calendar days, as required by Center for Medicare and Medicaid Services (CMS - an agency that administers the nation's major healthcare programs), for 19 of 27 residents reviewed for resident assessment (Residents 3, 14, 25, 30, 41, 45, 76, 81, 83, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141). This deficient practice resulted in late completion of quarterly assessments in Residents 3, 14, 25, 30, 41, 45, 76, 81, 83, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141, potentially resulting in delay in updating and creating residents' care plan affecting residents' quality of care. Findings: 1a. A record review of Resident 3's MDS Quarterly assessment dated [DATE], indicated Resident 3's assessment was completed on January 8, 2025, 53 calendar days after the assessment reference date (the final day of the observation period during which the resident's status is assessed and documented); 1b. A record review of Resident 14's MDS Quarterly assessment dated [DATE], indicated Resident 14's assessment was completed on January 8, 2025, 53 days after the assessment reference date; 1c. A record review of Resident 25's MDS Quarterly assessment dated [DATE], indicated Resident 25's assessment was completed on January 9, 2025, 46 days after the assessment reference date; 1d. A record review of Resident 30's MDS Quarterly assessment dated [DATE], indicated Resident 30's assessment was completed on January 5, 2025, 53 days after the assessment reference date; 1e. A record review of Resident 41's MDS Quarterly assessment dated [DATE], indicated Resident 41's assessment was completed on January 8, 2025, 52 days after the assessment reference date; 1f. A record review of Resident 45's MDS Quarterly assessment dated [DATE], indicated Resident 45's assessment was completed on January 7, 2025, 58 days after the assessment reference date; 1g. A record review of Resident 76's MDS Quarterly assessment dated [DATE], indicated Resident 76's assessment was completed on January 3, 2025, 54 days after the assessment reference date; 1h. A record review of Resident 81's MDS Quarterly assessment dated [DATE], indicated Resident 81's assessment was completed on January 10, 2025, 49 days after the assessment reference date; 1i. A record review of Resident 83's MDS Quarterly assessment dated [DATE], indicated Resident 83's assessment was completed on January 10, 2025, 35 days after the assessment reference date; 1j. A record review of Resident 86's MDS Quarterly assessment dated [DATE], indicated Resident 86's assessment was completed on January 9, 2025, 41 days after the assessment reference date; (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1k. A record review of Resident 89's MDS Quarterly assessment dated [DATE], indicated Resident 89's assessment was completed on January 3, 2025, 56 days after the assessment reference date; 1l. A record review of Resident 106's MDS Quarterly assessment dated [DATE], indicated Resident 106's assessment was completed on January 11, 2025, 34 days after the assessment reference date; 1m. A record review of Resident 124's MDS Quarterly assessment dated [DATE], indicated Resident 124's assessment was completed on January 10, 2025, 49 days after the assessment reference date; 1n. A record review of Resident 127's MDS Quarterly assessment dated [DATE], indicated Resident 127's assessment was completed on January 5, 2025, 51 days after the assessment reference date; 1o. A record review of Resident 128's MDS Quarterly assessment dated [DATE], indicated Resident 128's assessment was completed on January 8, 2025, 51 days after the assessment reference date; 1p. A record review of Resident 129's MDS Quarterly assessment dated [DATE], indicated Resident 129's assessment was completed on January 9, 2025, 49 days after the assessment reference date; 1q. A record review of Resident 130's MDS Quarterly assessment dated [DATE], indicated Resident 130's assessment was completed on January 7, 2025, 45 days after the assessment reference date; 1r. A record review of Resident 131's MDS Quarterly assessment dated [DATE], indicated Resident 131's assessment was completed on January 7, 2025, 53 days after the assessment reference date; 1s. A record review of Resident 141's MDS Quarterly assessment dated [DATE], indicated, Resident 141's assessment was completed on January 11, 2025, 34 days after the assessment reference date. On January 17, 2025, at 11:26 a.m. a concurrent interview and record review was conducted with the MDS Coordinator (MDSC). The MDSC reviewed the quarterly assessments for Residents 3, 14, 25, 30, 41, 45, 76, 81, 83, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141 and stated all the resident's quarterly assessments were completed late, passed the 14 days requirement. The MDSC further stated it was important to complete the assessments on time to ensure accuracy and avoid delay in residents plan of care. On January 17, 2025, at 4:02 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the quarterly assessments for Residents 3, 14, 25, 30, 41, 45, 76, 81, 83, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141 should have been completed within 14 days to ensure each resident had individualized resident centered care plans. A review of the facility policy and procedure title, MDS Completion and Submission Timeframes, dated July 2017, indicated, .The assessment coordinator or designee is responsible for .resident assessments . submitted to CMS .in accordance with current federal and state guidelines. A review of the facility document titled, RAI OBRA-required Assessment Summary dated October 2024, indicated, Assessment Type: Quarterly (Non-Comprehensive) .MDS Completion Date (item Z0500B .No Later Than .ARD +14 calendar days .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 50309 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS - an assessment tool) annual and quarterly assessments were transmitted timely for 21 of 27 residents (Residents 3, 14, 25, 30, 41, 45, 70, 76, 81, 83, 85, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141) reviewed for resident assessment. This failure had the potential to cause gaps in the development or implementation of the resident's care plan, potentially affecting the quality of care. Findings: On January 17, 2025, at 11:26 a.m., a concurrent interview and record review of Residents 3, 14, 25, 30, 41, 45, 70, 76, 81, 83, 85, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141's MDS assessments were conducted with the MDS Coordinator (MDSC). The resident assessments indicated the following: 1. Resident 3's MDS Quarterly assessment had an Assessment Reference Date (ARD - the final day of the observation period for the MDS assessment) of November 16, 2024, and was transmitted on January 8, 2025; 2. Resident 14's MDS Quarterly assessment had an ARD of November 16, 2024, and was transmitted on January 8, 2025; 3. Resident 25's MDS Quarterly assessment had an ARD of November 24, 2024, and was transmitted on January 10, 2025; 4. Resident 30's MDS Quarterly assessment had an ARD of November 13, 2024, and was transmitted on January 6, 2025; 5. Resident 41's MDS Quarterly assessment had an ARD of November 17, 2024, and was transmitted on January 9, 2025; 6. Resident 45's MDS Quarterly assessment had an ARD of November 10, 2024, and was transmitted on January 7, 2025; 7. Resident 70's MDS Annual assessment had an ARD of December 5, 2024, and was transmitted on January 12, 2025; 8. Resident 76's MDS Quarterly assessment had an ARD of November 10, 2024, and was transmitted on January 6, 2025; 9. Resident 81's MDS Quarterly assessment had an ARD of November 22, 2024, and was transmitted on January 11, 2025; (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Resident 83's MDS Quarterly assessment had an ARD of December 6, 2024, and was transmitted on January 10, 2025; 11. Resident 85's MDS Annual assessment had an ARD of December 7, 2024, and was transmitted on January 12, 2025; 12. Resident 86's MDS Quarterly assessment had an ARD of November 29, 2024, and was transmitted on January 10, 2025; 13. Resident 89's MDS Quarterly assessment had an ARD of November 8, 2024, and was transmitted on January 6, 2025; 14. Resident 106's MDS Quarterly assessment had an ARD of December 8, 2024, and was transmitted on January 12, 2025; 15. Resident 124's MDS Quarterly assessment had an ARD of November 22, 2024, and was transmitted on January 11, 2025; 16. Resident 127's MDS Quarterly assessment had an ARD of November 15, 2024, and was transmitted on January 6, 2025; 17. Resident 128's MDS Quarterly assessment had an ARD of November 18, 2024, and was transmitted on January 9, 2025; 18. Resident 129's MDS Quarterly assessment had an ARD of November 21, 2024, and was transmitted on January 10, 2025; 19. Resident 130's MDS Quarterly assessment had an ARD of November 23, 2024, and was transmitted on January 8, 2025; 20. Resident 131's MDS Quarterly assessment had an ARD of November 15, 2024, and was transmitted on January 8, 2025; 21. Resident 141's MDS Quarterly assessment had an ARD of December 8, 2024, and was transmitted on January 12, 2025; The MDSC stated the annual assessments for Residents 70 and 85, and quarterly assessments for Residents 3, 14, 25, 30, 41, 45, 76, 81, 83, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141 were not completed within 14 days from the ARD and were transmitted late to CMS (Centers for Medicare and Medicaid Services - an agency that administers national health care programs). The MDSC further stated it was important to complete and transmit the assessments on time to ensure the plan of care for the residents were accurate and avoid delay in their care. On January 17, 2025, at 4:02 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the assessments for Residents 3, 14, 25, 30, 41, 45, 70, 76, 81, 83, 85, 86, 89, 106, 124, 127, 128, 129, 130, 131 and 141 should have been completed within 14 days and transmitted to CMS in a timely manner to ensure each resident had individualized resident centered care plans. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy and procedure title, MDS Completion and Submission Timeframes, dated July 2017, indicated, .The assessment coordinator or designee is responsible for .resident assessments . submitted to CMS .in accordance with current federal and state guidelines . A review of Resident Assessment Instrument Manual Version 3.0, indicated, .Transmitting MDS Data . Completion Timing .For all non-admission OBRA (Omnibus Budget Reconciliation Act) .assessments, the MDS completion date (Z0500B) must be no later than 14 days after the ARD (Assessment Reference Date) . Submission Time Frame for MDS Records .Assessments .submit by Z0500B + 14 days (14 days from the completion date) .

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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** 44270 Based on observation, interview, and record review, the facility failed to notify the physician when the resident missed a follow-up visit for a surgical wound to the spine for one of six residents reviewed for skin conditions (Resident 24). This failure had the potential to delay the care and treatment of Resident 24's skin condition which could result in skin infections and worsening of the wound. Findings: On January 14, 2025, at 2:08 p.m., a concurrent observation and interview were conducted with Resident 24. Resident 24 was alert and sitting up in a chair. Resident 24 stated he missed his follow-up visit with a physician for his wound, was dismissed by staff, and was unsure if he was rescheduled for a new follow-up visit. Resident 24's record was reviewed. Resident 24 was admitted to the facility on [DATE], with diagnoses which included disease of the spinal cord (a weakened portion of the spine), and pressure ulcer of unspecified site, unspecified stage (skin breakdown). A review of Resident 24's history and physical dated December 2, 2024, indicated Resident 24 has the capacity to understand and make decisions. A review of the Physicians Summary, indicated, .Neurosurgery Follow up .01/13/25 @ 0945am .(address and phone number of appointment designation) .no imaging needed .Transportation arranged with .Pick up @ 8:56am (authorization number) .one time only until 01/13/2025 23:59 . A review of Resident 24's progress note dated January 13, 2025 at 11:43 a.m., indicated, .Residents transportation arrived late .Dr. refused to see resident due to being late to appointment. Sent communication to reschedule appointment . Further review of Resident 24's record medical record indicated there was no documentation the physician was notified of Resident 24 missed neurosurgery follow-up visit. In addition, there was no documentation that the missed neurosurgery follow-up visit was rescheduled. On January 16, 2025, at 2:01 p.m., a concurrent interview and record review was conducted with LVN 6. LVN 6 stated missed follow-up visits should be communicated to the physician and the scheduler (Case Manager) so that the visit could be rescheduled. LVN 6 stated, Resident 24's missed neurosurgery follow-up visit was not communicated to the staff and the physician was not notified. LVN 6 further stated the physician should have been notified of Resident 24's missed follow-up visit to ensure Resident 24 received the necessary care and treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 16, 2025, at 2:20 p.m. an interview was conducted with the Case Manager (CM). CM stated she was not made aware that Resident 24 missed a physician's follow-up visit on January 13, 2025. The CM stated the nursing staff should have communicated with the CM to ensure missed follow-up visits were rescheduled. The CM further stated that it was important for residents attend their appointments to receive necessary care and treatment and there was a risk that they would not receive the necessary care and treatment if they missed follow-up visits. On January 16, 2025, at 3:24 p.m., a concurrent interview and record review were conducted with the Director of Nursing (DON). The DON stated it was the responsibility of the licensed nurses to communicate with the physician, nursing staff, and case manager when residents miss follow-up visits. The DON stated licensed nurses should communicate follow-up visits with CM for rescheduling immediately. The DON stated if the staff did not communicate missed appointments to the physician and the CM, there could be potential risks for residents not receiving the necessary care and treatment. The DON stated there was no documentation, the physician was notified and all staff should communicate using the appropriate electronic medical record and paper forms.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on observation, interview, and record review, the facility failed to ensure for one of six residents (Resident 104) reviewed for pressure injuries: 1. The care plan interventions for the right heel pressure injury (PI - localized damage to the skin and underlying soft tissue over a bony prominence or from a medical device) were implemented. 2. The Registered Dietitian (RD) nutritional recommendations for wound healing were communicated to the physician. These failures had the potential to result in Resident 104 not receiving the necessary nutrition and devices needed to heal and prevent the worsening of the pressure injury. Findings: A review of Resident 104's Admission Record, indicated Resident 104 was admitted to the facility on [DATE], with diagnoses which included protein-calorie malnutrition (a condition where the body does not get enough protein and nutrients from food). A review of Resident 104's History and Physical dated December 22, 2024, indicated Resident 104 has the capacity to make decisions. A review of Resident 104's Minimum Data Set (an assessment tool) dated December 27, 2024, indicated, . Section M - Skin Conditions .Unhealed Pressure Ulcer/Injuries: Yes .Skin Ulcer/Injury Treatments: Pressure reducing device for bed (a special mattress designed to minimize pressure on a person's body while lying in bed) . 1. A review of Resident 104's Care Plan, indicated the following: - Dated December 24, 2024, indicated, .Focus: The resident has .impairment to skin integrity of the right heel .Pressure ulcer stage 4 (wound with deep tissue loss with exposed bone or muscle) .Interventions .Heel Elevation (offloading) . - Dated January 10, 2025, indicated, .Focus: Skin .Resident has pressure ulcer to (Right Heel) .Interventions . Pressure relieving device for heels (medical device specifically designed to reduce pressure on the heel area to treat the PI) . On January 17, 2025, at 10:51 a.m., during a concurrent interview and review of Resident 104's medical record with the Treatment Nurse (TN), she stated Resident 104 has a PI to the right heel with treatment interventions including heel elevation (offloading) and the use of pressure-relieving/reducing devices for Resident 104. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 17, 2025, at 1:50 p.m., during a concurrent observation and interview inside Resident 104's room with the TN, it was observed that Resident 104's heels and bed had no pressure relieving/reducing devices. Further observation revealed that Resident 104's heels were not offloaded from the bed. The TN stated Resident 104's heels were not offloaded and had no pressure relieving device in place. The TN further stated Resident 104 did not have a pressure reducing mattress and was lying on a regular mattress. The TN stated Resident 104 should have been provided pressure relieving/reducing devices and had her heels offloaded to promote wound healing and prevent worsening of the PI. The TN stated the facility had not followed Resident 104's plan of care and treatment interventions. On January 17, 2025, at 2:38 p.m., during a concurrent interview and review of Resident 104's medical record with the Director of Nursing (DON), she stated when a resident has a pressure injury, the TN would assess the PI and provide recommendation and preventative measures, such as offloading, and pressure-relieving/reducing devices. The DON stated Resident 104 had a PI to the right heel and no pressure relieving devices were in place. The DON further stated the TN should have followed the care plan interventions, offloaded Resident 104's heels, and provided pressure relieving devices for the resident's heels and bed to promote wound healing. The DON stated it is the facility practice and expectation that all nurses implement and follow the plan of care. A review of the facility policy and procedure titled, Care Plans, Comprehensive Person Centered, dated December 2016, indicated, .A comprehensive, person -centered care plan that includes measureable objectives .to meet the resident physical .needs is developed and implemented .The Interdiciplinary Team, in conjuction with te resident .implements a .person centered care plan . 2. A review of Resident 104's Nutritional Risk Assessment, dated December 27, 2024, indicated, . Recommendations .Order Daily MVM (sic) (Multivitamin) w/ (with) minerals .CBC/CMP (Complete Blood Count/Comprehensive Metabolic Panel - laboratory blood test) . A review of Resident 104's Progress Notes, from December 2024 through January 2025, did not indicate the physician, and or the medical director was notified of the RD recommendations. On January 17, 2025, at 4:11 p.m., during an interview with RD 2, she stated when a resident is admitted with a PI, the RD assesses the resident's nutritional needs and provides recommendations for supplementation, vitamins, minerals, and laboratory testing to support wound healing. RD 2 further stated the recommendations are provided to nursing who are responsible for communicating the recommendations to the physician or the medical director for further instructions and orders. RD 2 stated on December 27, 2024, RD recommended that Resident 104 receive a daily MVM with minerals and laboratory blood test. RD 2 further stated the recommendations were not communicated to the physician or the medical director and were not implemented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 17, 2025, at 4:47 p.m., during a concurrent interview and review of Resident 104's medical record with the DON, she stated when the RD provides recommendations for supplementation, vitamins, minerals and or laboratory testing to address a PI, the licensed nurses (LN's) review the recommendations and communicate them with the resident's physician for further instructions. The DON further stated if the physician is unavailable, the medical director should be notified of the recommendations. The DON stated on December 27, 2024, the RD recommended ordering daily MVM with minerals and laboratory blood test for Resident 104's PI and the physician or the medical director was not notified. The DON further stated the LN's should have followed up, called, and notified the medical director of the RD recommendations when the physician was unreachable to ensure Resident 104 received the necessary nutrition for wound healing. The DON stated the facility did not have a specific policy regarding the communication of RD recommendations by nursing to physician or medical director, but further stated it was the facility practice and the expectation for all LN's. A review of the facility policy and procedure titled, Guidelines for Notifying Physicians of Clinical Problems, dated February 2014, indicated, .These guidelines are to help ensure that .medical care problems are communicated to the medical staff in a timely, efficient and effective manner .Other .Consultant reports .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to follow the physician's order for oxygen therapy, for one of six residents reviewed for respiratory care (Residents 49). This failure had the potential to place Resident 49 at risk of respiratory distress and a decline in medical condition. Findings: On January 13, 2025, at 10:59 a.m., during a concurrent observation and interview with Resident 49, Resident 49 was observed sitting in bed with a nasal cannula (a device used to deliver oxygen) attached to his nose, with the oxygen set at zero liters per minute (LPM- unit of measurement). Resident 49 stated he used oxygen to help with his breathing. A review of Resident 49 Admission Record, indicated, Resident 49 was admitted to the facility on [DATE], with multiple diagnoses that included pulmonary fibrosis (a chronic lung disease making it difficult to breathe) and anxiety (a feeling of fear, dread, and uneasiness). A review of Resident 49's Order Summary Report for the month of January 2025, indicated, .Oxygen at 2 LPM via Nasal Cannula as needed for SOB (shortness of breath)/ Sats (saturation - measure the percentage of oxygen in the blood) less than 90% . On January 13, 2025, at 11:05 a.m., during a concurrent observation and interview with Licensed Vocational Nurse (LVN 4) in Resident 49's room, LVN 4 stated Resident 49's oxygen level was set at 0 LPM. LVN 4 stated, Resident 49 should have been receiving oxygen at 2 LPM per physician's orders. LVN 4 further stated that it was the nurse's responsibility to ensure that the physician's order was followed. On January 16, 2025, at 3:12 p.m., during an interview with the Director of Nursing (DON), the DON stated, the oxygen order should be followed as prescribed by the physician to prevent distress, low oxygen saturation, or a change in the resident's condition. A review of the facility's policy and procedures titled, Oxygen Administration, dated 2001 indicated, .verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration .adjust the oxygen delivery devise so that it is comfortable for the resident and the proper flow of oxygen is being administered .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on interview and record review the facility failed to ensure for one of six residents (Resident 152), a pain assessment and evaluation was conducted before and after the administration of narcotic (controlled drug that induces stupor, coma, or insensibility to pain) pain medication from December 2024 through January 2025. This failure had the potential to result in unrelieved or ummanaged pain, which could lead to a decline in Resident 152's overall health and well-being. Findings: A review of Resident 152's Admission Record, indicated Resident 152 was admitted to the facility on [DATE], with diagnoses which included rheumatoid arthritis (inflammation in the joints that causes pain and swelling). A review of Resident 152's History and Physical, dated December 6, 2024, indicated Resident 152 had the capacity to understand and make decisions. A review of Resident 152's Order Summary Report, dated December 2, 2024, indicated, .Norco (a narcotic) Oral Tablet 5-325 mg (milligram - unit of measurement) Hydrocodone-Acetaminophen (generic name for Norco) give 1 (one) tablet by mouth every 6 (six) hours as needed for pain 4-10 (moderate to severe pain level) . A review of Resident 152's Care Plan, dated December 23, 2024, indicated, .Focus: Pain: At risk for pain or discomfort due to arthritis (rheumatoid) .Interventions .Administer medications as ordered .Assess pain .as indicated . A review of Resident 152's Medication Administration Record (MAR), from December 2024 through January 2025, did not indicate the Licensed Nurse (LN) conducted pain assessment prior to administering Norco to Resident 152. In addition, there was no documented evidence the LN evaluated Resident 152 after the PRN (as needed) pain medication was administered. On January 15, 2025, at 3:21 p.m., during a concurrent interview and record review of Resident 152's MAR and controlled drug record with Registered Nurse (RN) 1, she stated when a resident asked for pain medication, the LN should assess the resident's pain level and location, sign out the pain medication on the Controlled Drug Record, administer the medications to the resident. RN 1 stated the licensed nurse should document the pain assessment and medication administration in the resident 's MAR. RN 1 stated the licensed nurse should conduct a pain reassessment after one hour to evaluate the effectiveness of the medication. RN 1 stated the pain assessments before and after administering Norco should have been documented in the MAR but were missing for Resident 152. RN 1 stated, Resident 152's Norco was signed out on the controlled drug record by a LN and Resident 152 was not assessed or re-assessed for pain prior and after medication administration on the following dates: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- December 4, 2024 at 5:10 a.m. - December 8, 2024 at 8 a.m. - December 11, 2024 at 2:45 p.m. and 9 p.m. - December 13, 2024 at 9 p.m . - December 17, 2024 at 3:45p.m. and 8 p.m. - December 24, 2024 at 6 p.m. - December 31, 2024 at 7 p.m., and - January 11, 2025 at 10 p.m. On January 16, 2025, at 9:17 a.m., during an interview and review of Resident 152's MAR and controlled drug record with the Director of Nursing (DON), she stated the facility's process for administering PRN narcotic pain medications requires the LN to conduct a pain assessment before administration, sign out the narcotic from the Controlled Drug Record, administer the medication to the resident, document in the resident's MAR the date, time, pain location, and pain level at the time of administration, and evaluate and document the effectiveness of medication after administration. The DON stated Licensed Vocational Nurse (LVN) 5 signed out Resident 152's Norco on the dates reviewed but did not document or follow the facility's process for PRN narcotic pain medication administration. The DON further stated LVN 5 should have documented the pain assessment, medication administration, and reevaluation of the medication's effectiveness to ensure Resident 152's pain was managed properly and to prevent medication errors taht could lead to adverse outcomes (negative events such as injury, illness or fatality that are often linked to medication errors) and or death. On January 16, 2025, at 12:10 p.m., during an interview with LVN 5, she stated she was the licensed nurse who signed out Resident 152's Norco. LVN 5 stated, she did not document the medication administration in the MAR and did not assess Resident 152's pain level. LVN 5 further stated she should have documented, assessed, and re-evaluated Residents 152's pain to prevent unrelieved and unmanaged pain. A review of the facility policy and procedure titled, Administering Pain Medications, dated March 2020, indicated, .The purpose if this procedure is to provide guidelines for assessing the resident level of pain prior to administering .pain medications .Conduct pain assessment .Administer pain medication as ordered . Re-evaluate the resident level of pain .after administering .Document the following in the resident's medical record: Results of pain assessment .Medication .Dose .Route of administration; and Results of the medication .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202 Based on observation, interview, and record review, the facility failed to ensure the PRN (as needed) narcotic (controlled drug that induces stupor, coma, or insensibility to pain) pain medications that were signed out were properly administered and recorded in the Medication Administration Record (MAR), for one of six residents (Resident 152). This failure resulted in delays in identifying medication discrepancies and increased the risk of controlled substance diversion. Findings: A review of Resident 152's Admission Record, indicated Resident 152 was admitted to the facility on [DATE], with diagnoses which included rheumatoid arthritis (inflammation in the joints that causes pain and swelling). A review of Resident 152's History and Physical dated December 6, 2024, indicated Resident 152 has the capacity to understand and make decisions. A review of Resident 152's Order Summary Report, dated December 2, 2024, indicated, .Norco (a narcotic) Oral Tablet 5-325 mg (milligram - unit of measurement) Hydrocodone-Acetaminophen (generic name for Norco) give 1 (one) tablet by mouth every 6 (six) hours as needed for pain 4-10 (moderate to severe pain level) . A review of Resident 152's Controlled Drug Record, dated December 2024 through January 2025, indicated 10 doses of Hydrocodone-Acetamin (sic) (Acetaminophen) 5-325 mg were signed out by the LN on the following dates: - December 4, 2024 at 5:10 a.m. - December 8, 2024 at 8 a.m. - December 11, 2024 at 2:45 p.m. and 9 p.m. - December 13, 2024 at 9 p.m. - December 17, 2024 at 3:45 p.m. and 8 p.m. - December 24, 2024 at 6 p.m. - December 31, 2024 at 7 p.m., and - January 11, 2025 at 10 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 152's Medication Administration Record (MAR), from December 2024 through January 2025, indicated there was no documented evidence Norco was administered to Resident 152. On January 15, 2025, at 3:21 p.m., during a concurrent interview and review of Resident 152's MAR and controlled drug record with Registered Nurse (RN) 1, she stated when a resident requests pain medication, the Licensed Nurse (LN) assesses the resident's pain level and location, signs out the medication on the controlled drug record, and administers the medication to the resident. RN 1 further stated the pain assessment and medication administration must be documented in the resident's MAR, and a pain reassessment should be conducted after one hour to evaluate the effectiveness of the pain medication. RN 1 stated Resident 152's Norco was signed out on the controlled drug record but was not documented as administered in the MAR. On January 16, 2025, at 9:17 a.m., during an interview and review of Resident 152's MAR and controlled drug record with the Director of Nursing (DON), she stated the LN should conduct a pain assessment, sign out the medication from the controlled drug record, administer the medication to the resident, document in the resident's MAR the date and time of administration, pain level and location of pain, and evaluate the effectiveness of the pain medication. The DON stated Licensed Vocational Nurse (LVN) 5 signed out Resident 152's Norco on the dates reviewed and did not document the administration of the medication in the resident's MAR. The DON stated, LVN 5 was not following the facility's process for PRN narcotic pain medication administration. The DON further stated LVN 5 should have documented the administration of the PRN pain medication in the MAR to ensure accountability for all narcotic medication and to prevent any medication diversion. On January 16, 2025, at 12:10 p.m., during an interview with LVN 5, she stated she signed out and administered Resident 152's Norco and did not document the medication administration in the resident's MAR. LVN 5 further stated she should have documented the Norco in the MAR to ensure narcotic accountability and maintain accurate medication records. A review of facility policy and procedure titled, Medication Administration Controlled Substances, dated 2007, indicated, .When a controlled medication is administered the license nurse administering the medication immediately enters the following information on the accountability record .Date and time of administration . Amount administered .Signature of the nurse administering the dose .Document the dose administration on the MAR . A review of facility policy and procedure titled, Medication Administration General Guidelines, dated 2007, indicated, .The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given .In no case should the individual who administered the medication report off-duty without first recording the administration of any medications .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50309 Based on observation, interview, and record review, the facility failed to provide food with appetizing taste for 10 of 177 sampled residents (Residents 102, 104, 124, 130, 123, 6, 253, 140, 27 and 85). This failure had the potential to decrease the nutritional intake and affect Residents 102, 104, 124, 130, 123, 6, 253, 140, 27 and 85's nutritional status. Findings: On January 13, 2025, the following interviews were conducted: - at 10:00 a.m., Resident 102 stated, the food is not good, it's a mess, noodles gummy. - at 11:10 a.m., Resident 104 stated, the food is too small and tiny, not good. - at 11:37 a.m., Resident 124 stated, the food taste awful, and they served overcooked and burnt eggs. - at 11:40 a.m., Resident 130 stated, the food does not taste good. - at 12:36 p.m., Resident 123 stated, the food was not good, too bland, and no taste. - at 4:09 p.m., Resident 6 stated, I do not like the food, the rice is hard. On January 14, 2025, the following interviews were conducted: - at 9:45 a.m., Resident 253 stated, the food was just okay, it was hospital food. - at 10:20 a.m., Resident 140 stated, the food was pathetic, has no appeal, and has no flavor. - at 11:10 a.m., Resident 27 stated, the food was so-so, the chicken was dry, the pork was pink, and the pasta was soggy. On January 15, 2025, at 10:02 a.m., Resident 85, stated, the food was not fresh, the vegetables were over-steamed and the pasta tasted like wet flour. On January 15, 2025, at 1:11 p.m., a concurrent observation and interview of a test tray (to evaluate the quality of a meal during a meal service and identify any areas for improvement) was conducted with the Dietary Services Supervisor (DSS). The DSS stated the pureed noodles, pureed peas, and pureed chicken were bland and lacked flavor. The DSS further stated the lack of flavor could result in residents not wanting to eat the food and could lead to unwanted weight loss. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On January 15, 2025, at 3:40 p.m., an interview was conducted with the Registered Dietitian (RD) 1. RD 1 stated dietary staff should provide flavorful food to encourage residents to eat their served meals and prevent unintended weight loss. A review of the facility policy and procedure titled, Food Preparation, dated 2023, indicated, .food shall be prepared by methods that conserve nutritive value, flavor . A review of the facility policy and procedure titled, Food and Nutrition Services, dated 2023, indicated, .it is the policy of this facility to serve nourishing attractive meals to all residents .to meet the nutritional needs of each individual resident .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50309 Based on observation, interview and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. Eight out of twelve storage shelves in the dry storage room had brown grime, corrosion, and chipped coating. 2. Seven out of seven storage shelves in the walk-in refrigerator had white buildup, brown grime, and dirt. 3. Seven out of seven storage shelves in the freezer had brown grime and chipped coating. 4. Two electric fans mounted on the wall above the preparation sink and dishwashing area had white debris on the blades and covers. These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) in a vulnerable population of 168 out of 177 residents who received food prepared in the kitchen. Findings: 1. On January 13, 2025, at 10:11 a.m., a concurrent observation and interview were conducted with the Dietary Services Supervisor (DSS) in the dry storage room. Eight out of twelve storage shelves had brown grime, corrosion, and chipped coating. Onions, potatoes, and canned goods were on these shelves. The DSS stated the shelves should have been cleaned more frequently. The DSS further stated, grime, corrosion, and chipping should not be present on the shelves to prevent cross contamination, which could lead to food borne illness to the residents. 2. On January 13, 2025, at 10:28 a.m., a concurrent observation and interview were conducted with the DSS in the walk-in refrigerator. Seven out of seven shelves had white buildup, brown grime, and dirt. Milk, eggs, vegetables, and fruits were stored on the shelves. The DSS stated the storage shelves should not have any white buildup, brown grime, or dirt and should be kept clean to prevent cross-contamination, which could lead to food borne illness to the residents. 3. On January 13, 2025, at 10:36 a.m., a concurrent observation and interview were conducted with the DSS in the walk-in freezer. Seven out of seven storage racks had brown grime and chipped coating. The DSS stated the storage racks should not have brown grime and chipped coating and should be kept clean to prevent cross-contamination, which could lead to food borne illness to the residents. 4a. On January 13, 2025, at 9:50 a.m., concurrent observation and interview were conducted with the DSS near the food preparation sink. A black fan mounted on the wall above the counter space of the sink was observed to have white debris on the blades and cover. The DSS stated the fan had dust buildup and should be cleaned more frequently to avoid cross-contamination of food which could cause food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4b. On January 13, 2025, at 11:42 a.m., concurrent observation and interview were conducted with the DSS near the dishwashing area. A black fan mounted on the wall above the dishwashing sink had white debris on the blades and cover. The DSS stated the fan had dust buildup and should be cleaned more frequently to avoid cross contamination of food which could cause foodborne illness. On January 15, 2025, at 3:40 p.m., an interview was conducted with the Registered Dietitian (RD) 1. RD 1 stated the storage shelves in the dry storage room, walk-in refrigerator and freezer should not have any grime, white buildup, dirt, corrosion or chipping and should be kept clean to prevent cross-contamination which could cause food borne illness. RD 1 further stated the fans above the preparation sink and dishwashing area should not have dust buildup and should be kept clean to prevent cross-contamination, which could cause food borne illness. During a review of the facility's policy and procedure titled, Sanitization, dated 2008, indicated, .2 .All . shelves .shall be kept clean .maintained in good repair and shall be free from break, corrosions .chipped areas that may affect their use or proper cleaning .18 .The Food services staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task .

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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 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** 44505 Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were implemented when: 1. Resident 290's oxygen humidifier (a medical device used to humidify oxygen) was found on the floor. 2. Resident 291's nasal cannula (a device used to deliver oxygen) was found on the floor. These failures had the potential to result in cross-contamination, increasing the spread of infection to an already vulnerable population of residents in the facility. Findings: 1. On January 13, 2025, at 12:10 p.m., Resident 290 was observed sitting in bed with oxygen via nasal cannula attached to an oxygen concentrator with the oxygen humidifier on the floor. On January 13, 2025, at 12:15 p.m., during an observation and interview with Licensed Vocational Nurse (LVN 1) in Resident 290's room, LVN 1 stated Resident 290 had an order for oxygen at 3 LPM for sob (shortness of breath). LVN 1 further stated that the oxygen humidifier should be attached to the concentrator and not placed on the floor to maintain infection control standards. Resident 290's Admission record was reviewed. Resident 290 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (lung disease that makes it difficult to breathe). Resident 290 had a physician's order for oxygen use with a humidifier for shortness of breath. On January 16, 2025, at 3:12 p.m., during an interview with the Director of Nursing (DON), the DON stated, there is a designated place for the oxygen humidifier, and it should not be on the floor to prevent infection. A review of policy and procedure titled, Oxygen Administration, dated October 2010, indicated, .check the mask, tank, humidifying jar, etc.to be sure they are in good working order and are securely fastened . A review of the facility policy and procedure titled, Policies and Procedures- Infection Prevention and Control, dated December 2023, indicated, .the facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections . 2. On January 14, 2025, at 11:50 a.m., Resident 291 was observed lying in bed without oxygen. Resident 291's nasal cannula was observed on the floor. (continued on next page)

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	01/17/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 14, 2025, at 11:55 a.m., during a concurrent observation and interview with the Certified Nursing Assistant (CNA 1) in Resident 291's room, CNA 1 was observed picking up the nasal cannula from the floor and placing it on Resident 291's nostrils. CNA 1 stated, she should have replaced the nasal cannula before placing it on Resident 291's nostrils, to prevent infection. Resident 291's Admission record was reviewed. Resident 291 was admitted to the facility on [DATE], with diagnosis which included dyspnea (shortness of breath) and COVID- 19 (an infectious disease). Resident 291 had a physician's order for continuous oxygen at 2 LPM via nasal cannula. On January 16, 2025, at 3:12 p.m., during an interview with the Director of Nursing (DON), the DON stated, a nasal cannula found on the floor should be discarded and replaced with a new one to prevent the spread of infection. A review of the facility policy and procedure titled, Infection Prevention and Control, dated December 2023, indicated, .the facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .