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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555623	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hemet Valley Healthcare Center	371 North Weston Pl Hemet, CA 92543

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43396 Based on observation, interview, and record review, the facility failed to ensure, for one of three sampled residents (Resident A), an injury of unknown origin was reported to the California Department of Public Health (CDPH) immediately, or not later than two hours, when Resident A was found to have a bluish discoloration on the side of the eye. This failure had the potential to result in a delay of the implementation of appropriate action and the provision of protection for Resident A and placed other residents at risk for further abuse. Findings: On March 28, 2024, at 3:10 p.m., an announced visit to the facility was conducted to investigate a facility reported incident regarding injury of unknown origin. On March 28, 2024, at 3:18 p.m., an interview was conducted with the Director of Nursing (DON). She stated Resident A's family notified the staff that they had noticed bruising on Resident A's left eyelid which the family member thought occurred when she was showered by the staff on December 25, 2023. The DON stated when she assessed the resident on December 25, 2023, she observed Resident A with slight brown and yellowish discoloration on the left eyelid. The DON stated it looked like it was an old bruise that was healing. The DON stated she investigated but the resident nor the staff were not able to identify how and when the discoloration occurred. The DON stated on December 14, 2023, it was documented by the licensed nurse that Resident A had a bruise on the left eyelid. Resident A's record was reviewed, and indicated the resident was admitted on [DATE], with diagnoses which included chronic respiratory failure, status post tracheostomy, and persistent vegetable state (a person who has loss of awareness of their surroundings). A review of the care plan dated July 9, 2020, indicated, .Resident has an increased potential for bleeding secondary to use of anticoagulant (a type of medication to thin the blood to prevent blot clot) .Resident will be free from signs and symptoms of bleeding daily .Monitor for S/S (sign and symptoms) of excessive anticoagulant .bruises .notify MD (doctor) . A review of the Short Term Care Plan, for the following dates indicated: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- December 14, 2023- .Bruise on left eyelid .monitor bruise on eyelid q (every) shift x (times) 3 (three) days then reassess on 12/19/2023 . - December 19, 2023- .Bruise on left eyelid .monitor bruise on L (left) eyelid q shift x 7 days then reassess on 12/26/2023 . A review of the Progress Notes dated December 25, 2023, at 4:40 p.m., indicated, .Patients (sic) daughter was in to visit patient and realized that patient has a bruise on her left eye .Sister and patient stated that she received the bruise from when she was given a shower . Further review of Resident A's record indicated no documented evidence Resident A's discoloration to the left eyelid was reported to CDPH after it was initially identified on December 14, 2023. On April 17, 2024, at 1:15 p.m., an interview with the DON was conducted. The DON stated when Resident A was hospitalized on [DATE], the family member had reported Resident A sustained a bruise on the left eyelid during shower which occurred back in December of 2023. She stated this was the same incident that was investigated back on December 25, 2023 (11 days from the time it was initially identified on December 14, 2023) but was not reported to CDPH. The DON stated this was considered an injury of unknown origin since Resident A and/or the staff was not able to identify the cause of the discoloration on the left eyelid. Therefore, she stated it should have been reported to CDPH within 2 hours after the injury was initially identified on December 14, 2023. She stated Resident A's bruise on the left eyelid was reported to CDPH on March 15, 2024 (81 days from the first time it was initially identified). The facility's policy and procedure titled PREVENTION OF ABUSE, dated April 4, 2021, was reviewed. The policy indicated, .IDENTIFYING SUSPECTED OR KNOWN DEPENDENT ADULT OR ELDERLY ABUSE . Complaints, observations of indicators, described below or others, of abuse (of suspicious or unknown origin), suspicious, or reporting of incident .bruises .will be investigated to rule out abuse .Indicators of Physical Abuse .bruises .REPORTING PROCEDURES/RESPONSES TO ALLEGATIONS OF ABUSE . Cases of suspected or known abuse will be given priority, investigated thoroughly, and reported immediately to the appropriate agency .designee shall make a telephone report to the local law enforcement immediately or as soon as possible and shall make a written report to the Department of Public Health, local law enforcement and the long-term care Ombudsman within 2 hours .

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F 0684 Level of Harm - 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** 43396 Based on interview and record review, the facility failed to ensure, for one of three sampled residents (Resident A): 1. Proper positioning of a female resident with lower extremity (legs and feet) contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) was implemented during urine sample collection with the use of a straight catheter (a flexible tube inserted into the urethra [where urine passes out of the body]). Resident A's hip and leg/thigh were lifted up six inches from the mattress for urine collection. In addition, the licensed nurse continued to collect a urine sample from Resident A despite hearing an abnormal sound from Resident A's hip area. This failure resulted in Resident A to sustain a left hip fracture (broken bone) and was subsequently transferred to the acute hospital for surgical procedure; and 2. Resident A's bluish discoloration to the left eyelid was assessed, monitored, evaluated, and referred to the physician for appropriate treatment. This failure resulted in delayed provision of treatment to address Resident A ' s bluish discoloration to the left eyelid and could potentially compromise the resident ' s overall health condition. Findings: On March 28, 2024, at 3:10 p.m., an announced visit to the facility was conducted to investigate a facility reported incident and complaints regarding quality of care. 1. On March 28, 2024, at 3:43 p.m., an interview was conducted with Registered Nurse (RN) 1, RN 1 stated she worked as a charge nurse on the morning shift on March 13, 2024. RN 1 stated Resident A's had change of condition, and the physician ordered for urinalysis. She stated she instructed Licensed Vocational Nurse (LVN) 1 to collect urine from Resident A, and LVN 1 reported hearing a pop while trying to collect urine from Resident A. She stated the physician ordered x-ray (a photographic or digital image of the internal composition of something, especially a part of the body). She stated Resident A's x-ray indicated a fracture on the femur (hip) and Resident A was subsequently transferred to the acute care hospital. On March 28, 2024, at 4:02 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated she assisted LVN 1 in collecting urine from Resident A on March 13, 2024. CNA 2 stated she was at the left side of Resident A and CNA 1 was at the right side of Resident A. CNA 2 stated they (CNA 1, CNA 2, AND LVN 1) heard a pop when she lifted the resident's left leg. CNA 2 was asked to demonstrate how she lifted Resident A's leg, and CNA 2 was observed placing both hands under the resident's left leg and lifted it about six inches up from the mattress and CNA 2 stated that was the moment they heard the popping sound from Resident A's left thigh/hip area. She further stated LVN 1 reported to RN 1 that a popping sound was heard from Resident A's left hip and LVN 1 was instructed by RN 1 to still try to get the urine sample. (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

On March 28, 2024, at 4:36 p.m., an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated LVN 1 had asked her and CNA 2 for assistance in getting a urine sample from Resident A on March 13, 2024, at around 11:30 a.m. CNA 1 stated Resident A was very contracted on her upper and lower extremities with her hip towards the left side and the upper body was towards the right side. CNA 1 stated she and CNA 2 lifted (few inches above the mattress) Resident A ' s hip slightly to spread her legs so that LVN 1 could insert the catheter in her perineal area (area of the body between the anus and the vagina) to collect the urine sample, then they heard a pop. CNA 1 stated the popping sound came from Resident A's left hip. She stated LVN 1 left the room to report the incident to RN 1 and upon return to the room told CNAs 1 and 2 that the charge nurse instructed her (LVN 1) to collect the urine sample. She stated, during the second attempt to collect the urine sample, they lifted Resident A the same way and spread the resident's legs open while another LVN inserted the catheter on Resident A and finally got the urine sample. CNA 1 stated during the second attempt, RN 1 was present.

Resident A's admission record was reviewed. Resident A was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure (lung failure), status post tracheostomy (a surgical procedure to cut an opening on the neck to aid in breathing), and persistent vegetable state (a person who has loss of awareness of their surroundings).

A review of Resident A's History and Physical, dated January 27, 2024, indicated, .NEUROMUSCULAR . Restrictive ROM (range of motion [the extent or limit to which a part of the body can be moved around a joint or a fixed point]) .

A review of Resident A's Care Plan, dated January 27, 2024, indicated, .Immobility .Contractured Extremities .Position for comfort .

A review of Resident A's Progress Notes, indicated the following:

- March 13, 3024, at 11:15 a.m.; .MD (physician) ordered a UA (urinalysis - urine test) d/t (due to) residents (sic) change in mental status while straight cath (catheter), x (times) 2 (two) CNAs assist writer and the x (times) 2 (two) CNAs heard a pop noise that came from residents (sic) lip (sic) hip .writer and cnas stopped and and assessed residents left leg and left hip for any changes .

- March 13, 2024, at 11:35 a.m.; .Notified by LVN performing the urine collection that she heard a POP from the left hip while trying to collect the urine .MD ordered a (sic) X RAY left .Urine was collected and sent to lab .

- March 13, 2024, at 6:10 p.m.; .After sending left hip X-ray result to MD an order was received to transfer resident to DOU (Direct Observation Unit) under (name of doctor), due to left femur (thigh bone) fracture .

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On April 18, 2024, at 3:42 p.m., an interview with RN 1 was conducted. She stated on March 13, 2024, between 10 a.m. to 11 a.m., LVN 1 reported that when the CNAs lifted Resident A ' s legs while she was attempting to collect the urine sample, she heard a pop that came from Resident A's left hip. She stated LVN 1 reported that she did not feel comfortable in continuing to collect the urine sample. RN 1 stated she then asked another LVN to help. RN 1 stated she observed CNAs 1 and 2 lift the resident by the hip on each side with one hand on the hip and the other hand on her upper leg in which Resident A ' s lower part of the body was completely suspended several inches from the bed. RN 1 stated she realized that she should not have continued getting the urine sample after hearing the report from LVN 1 about the popping sound heard during the first attempt of urine collection. She also stated she should have stopped the CNAs when they lifted the resident from the hip and legs as she realized that this was probably not the safest positioning of the resident when the urine sample was collected. She further stated that they should have attempted to place the resident at side-lying position to prevent the fracture. On April 18, 2024, at 4:02 p.m., an interview with LVN 1 was conducted. LVN 1 stated Resident A ' s legs were very contracted. She described Resident A ' s legs on both sides to be internally rotated (knee and foot twist toward the midline of the body) with both knees almost touching each other. She further stated Resident A ' s legs on both sides could not be spread apart since there was resistance due to her contractures. LVN 1 stated on March 13, 2024, while CNAs 1 and 2 were helping her collect the urine sample for Resident A, using straight catheter, she heard a popping noise when the two CNAs lifted the resident from the hip on both sides. She stated she immediately told the CNAs to stop and bring Resident A back down in bed. She stated she reported to RN 1 the popping noise while positioning the resident during urine sample collection but was told that urine sample was still needed. She further stated she told RN 1 she did not feel comfortable collecting the sample. She stated, RN 1 brought another LVN to Resident A ' s room who eventually was able to collect the urine sample using straight catheter. LVN 1 stated she observed the CNAs lifting Resident A ' s hip on both sides when the other LVN collected the urine sample, which was the same procedure they did on the first attempt. LVN 1 stated after further discussion of the incident, she realized the positioning of Resident A when the urine sample was collected was probably not the safest to prevent injuries. On April 18, 2024, at 4:19 p.m., an interview with CNA 2 was conducted. She stated Resident A ' s legs on both sides could not be spread apart due to her contractures. She stated on March 13, 2024, CNA 2, and CNA 1 assisted LVN 1 in collecting the urine sample from Resident A. CNA 2 stated Resident A was lying in bed on her back with both of her knees slightly bent at the knees. CNA 2 stated she was on the left side of the bed while CNA 2 was on the opposite side. CNA 2 stated they (CNA 1 and CNA 2) lifted Resident A from her hip on each side with one hand on the hip and other hand right below the upper leg. She stated Resident A ' s lower part of the body was completely suspended in the air about several inches above the bed while LVN 1 attempted to collect the urine sample. She stated while LVN 1 was attempting to collect the urine sample, they heard a pop that came from resident ' s left hip and immediately placed resident ' s lower body back in bed. She stated LVN 1 left the room to report the popping sound from Resident A's left hip to RN 1. She stated LVN 1 came back with RN 1 and another LVN to continue with collecting the urine sample. CNA 2 stated they used the same positioning by lifting Resident A ' s hip and leg as they did on the first attempt. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On April 18, 2024, at 4:56 p.m., an interview was conducted with the Medical Doctor (MD). The MD stated she was aware of the incident that occurred on March 13, 2024, for Resident A. The MD stated the staff reported that the resident sustained a fracture on her left hip after the staff attempted to collect the urine sample. She stated she was not aware the CNAs who assisted with collecting the urine sample had lifted the resident by the hip and legs. She stated due to the resident's lower legs contracture, other position like side-lying would have been the safest way to collect the urine sample from Resident A. She stated Resident A ' s left hip fracture was likely caused by improper positioning of the resident when the urine sample was collected by the staff. She further stated if the staff reported that they heard a pop on the first attempt to collect urine, she would not have them continue collecting urine sample from Resident A. She stated due to improper positioning by the staff, the resident had to go to the hospital for a surgical procedure. On April 18, 2024, at 5:27 p.m., an interview with the DON was conducted. She stated she was not aware the CNAs who assisted with collecting the urine sample from Resident A had lifted resident from the hip and legs while suspended in the air. She stated this was not the proper positioning to collect the urine sample since she was aware of Resident A ' s contractures. She was surprised how the resident was positioned considering the weight of the resident and the LVN who collected the urine sample was able to insert the catheter without spreading her legs apart. She stated the staff who was involved during the time of the incident should have attempted to place resident in side-lying position instead of being lifted by the hip and legs to prevent injuries to the resident. She also stated RN 1 should not have instructed the LVN to continue with urine sample collection after hearing the report from LVN 1 about the popping noise that was heard after the first attempt. The DON further stated the cause of the fracture was likely due to improper positioning of the resident by her staff, considering the location of the fracture. The DON stated the facility did not have a policy and procedure related to the urine collection through straight catheter. A review of a web article titled Urinary Catheters- Clinical Procedures for Safer Patient Care, published on 2015, by Glunda [NAME] and [NAME] McCutheon, indicated, .Positioning of patient depends on gender . Patients should be comfortable, with perineum (an area between the anus and vagina) or penis exposed, for ease and safety in completing the procedure .Female patient: On back with knees flexed and thighs relaxed so that hips rotate to expose perineal area. Alternatively, if patient cannot abduct leg at the hip, patient can be side lying with upper leg flexed at knee and hip, supported by pillows . A review of the facility ' s policy and procedure titled General Restorative & Supportive Nursing Care, dated April 4, 2021, indicated, .It is the policy of this facility that each resident will be provided with an individualized restorative and supportive plan of care to allow the resident the highest degree of independence possible within their physical and mental capabilities .Restorative and supportive care shall include .Maintaining good body alignment and proper positioning of bedfast and dependent residents . A review of Resident A's (name of hospital) Discharge Summary, dated March 21, 2024, indicated, . ADMISSION DIAGNOSES: Left hip fracture .HOSPITAL COURSE: The patient .was getting a urinalysis when the nurse heard a popping sound on the left hip. X-ray was done showing a left hip fracture .The patient with left hip fracture, status post repair with ORIF (Open reduction and internal fixation [a type of surgery used to stabilize and heal a broken bone]) by (name of doctor) . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. On March 28, 2024, at 3:18 p.m., an interview was conducted with the Director of Nursing (DON). She stated Resident A ' s family member notified the staff on December 25, 2023, that they had noticed bruising on her left eye which she thought occurred when the resident was showered by the staff. The DON stated when she assessed Resident A on December 25, 2023, she observed Resident A with slight brown and yellowish discoloration on her left eyelid. The DON stated it looked like it was an old bruise that was healing. The DON stated she conducted interviews of the CNAs who showered resident on December 8, 2023, and denied ever noticing any discoloration to Resident A ' s left eyelid and that there was no incident that occurred during the shower on December 8, 2023. The DON stated after further review of Resident A ' s medical records, she noted a short-term care plan was initiated to monitor the resident's discoloration to her left eyelid on December 14, 2023. The DON further stated there was no further assessment, evaluation, and monitoring done to address resident ' s discoloration on her left eyelid after it was identified on December 14, 2023. Resident A ' s record was reviewed. Resident A was admitted on [DATE], with diagnoses which included chronic respiratory failure, status post tracheostomy, and persistent vegetable state (a person who has loss of awareness of their surroundings). A review of Resident A's Care plan, dated July 9, 2020, indicated, .Resident has an increased potential for bleeding secondary to use of anticoagulant (a type of medication to thin the blood to prevent blot clot) . Resident will be free from signs and symptoms of bleeding daily .Monitor for S/S (sign and symptoms) of excessive anticoagulant .bruises .notify MD (doctor) . A review of the Short Term Care Plan for the following dates indicated: - December 14, 2023 - .Bruise on left eyelid .monitor bruise on eyelid q (every) shift x (times) 3 (three) days then reassess on 12/19/2023 (December 19, 2023) . - December 19, 2023- .Bruise on left eyelid .monitor bruise on L (left) eyelid q shift x 7 days then reassess on 12/26/2023 (December 26, 2023) . In further review of Resident A ' s Progress Notes, there was no documented evidence Resident A ' s discoloration to the left eyelid was assessed, monitored, evaluated, and referred to the physician after it was identified on December 14, 2023. A review of Resident A's Progress Notes, indicated a Head to toe assessment was conducted for the following dates: December 14, 15, 17, 19, 25, and 26, of 2023. There was no documented evidence the discoloration on left eyelid was noted for Resident A. A review of the Progress Notes dated December 25, 2023, at 4:40 p.m., indicated, .Patients (sic) (family member) was in to visit patient and realized that patient has a bruise on her left eye . (Family member) and patient stated that she received the bruise from when she was given a shower . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On April 17, 2024, at 1:15 p.m., an interview with the DON was conducted. The DON stated when Resident A was hospitalized on [DATE], the family member had reported to the hospital staff that Resident A received a bruise during shower that occurred back in December of 2023. She stated that this was the same incident that was investigated on December 25, 2023, and did not find any issues with her staff providing rough care for Resident A. However, the DON stated the RN who had documented the bruise on Resident A ' s left eye lid on December 14, 2023, did not document in detail about the bruise on the left eyelid that was noted. In addition, the DON stated there was no documentation of any reassessment and/or reevaluation of the bruise, as well as notifying the physician after it was initially identified on December 14, 2023. The DON stated the family member should have been notified of the bruise on December 14, 2023. The facility ' s policy and procedure titled Change of Resident Condition dated April 2021, was reviewed. The policy indicated, .It is the policy of this facility that all changes in resident condition will be communicated to the physician .All symptoms and unusual signs will be communicated to the physician promptly. Routine changes are minor change in physical .that are not life threatening .The nurse in change is responsible for notification of the physician prior to end of assigned shift when a routine change in a resident ' s condition noted .Document resident change of condition and response in Nursing Progress Notes . The facility ' s policy and procedure titled BODY ASSESSMENT FOR SKIN dated April 2024, was reviewed. The policy indicated, .To provide an ongoing system for monitoring resident skin condition and to implement interventions, when needed, to prevent complications .It is the policy of this facility to monitor the resident ' s skin condition and provide documented licensed nurse assessments on an as needed and weekly basis . Nursing assistants will check resident ' s skin check according to weekly summary schedule .Licensed nurse will notify physician for orders and follow-up of treatment. Notify resident or family of changes in the resident ' s skin status .Licensed nurse will document findings in the weekly summary .