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	12/10/2025

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 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. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the shower gurney's (a mobile, waterproof device designed to transport and bathe individuals who cannot sit upright safely) wheel brakes, used to transfer one of three sampled residents (Resident 1), were locking properly to secure positioning during resident transfer and bathing.Findings:A review of Resident 1's admission record indicated that the resident was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure.A review of Resident 1's care plan titled Potential for Falls, dated June 4, 2022, indicated the resident has potential for falls related to sensory deficit, and poor endurance related to contractures of both lower extremities.A review of Resident 1's Minimum Data Set (MDS-an assessment tool), dated April 12, 2025, indicated the resident has no discernible consciousness and is dependent (Assistance of 2 or more helpers is required for the resident to complete the activity) with transfers and showers.A review of Resident 1's Progress Note Inquiry, dated June 4, 2025, indicated the following:-At 9:09 a.m., written by a licensed vocational nurse, Was attending Pt. (patient) in another room when I (LVN) called to (name of Resident 1) room. In the room Pt. was seen on the floor with RT (Respiratory Therapist-1) holding the head and the CNA (Certified Nursing Assistant) holding the feet area. CN (Charge Nurse) was called to the room, neuro assessment done .;-At 11:44 a.m., written by RT 1, SEE NURSES NOTES FOR FULL DETAILS. At approximately 0910 hours (9:10 a.m.), I (RT 1) was called into (room of Resident 1) to assist the CNA with a patient transfer from the patient's bed to the shower gurney .As we transferred the patient, the shower gurney slipped away and the patient slipped onto the floor .The patient's head never touched the floor, the patient buttocks & (and) legs did touch the floor .; and -At 12:54 p.m., written by a Registered Nurse (RN), . Called by staff to resident's room. Found Rrsident (sic) lying on the floor. Per RT (RT 1) they were transferring resident for shower. During transfer from bed to the shower gurney, there was a shift in the resident's weight and patient slipped to the floor with the RT holding on to the head of the resident during the fall .On December 10, 2025, at 9:53 a.m., during a concurrent observation and interview, Resident 1 was observed in her room, lying in bed with head of bed elevated at 45 degrees. Resident 1's eyes were closed, with tracheostomy connected to ventilator and enteral feeding (liquid nutrition delivered via a tube directly to the stomach or small intestine) turned on. Resident 1 was non-verbal.On December 10, 2025, at 2:31 p.m., during interview, CNA 1 stated that she was assigned to Resident 1 on June 4, 2025. She and RT 1 transferred Resident 1 from the bed to the shower gurney. CNA 1 stated that the shower gurney's wheel brakes were not locking properly and the shower gurney moved during the transfer.On December 10, 2025, at 2:57 p.m., during an interview, RT 1 stated that on June 4, 2025, the shower gurney's (shower gurney used on Resident 1) wheel brakes did not lock well. RT 1 stated that they tried to lock the wheel brakes of the shower gurney, then the gurney slipped as they were transferring Resident 1 from bed to the shower gurney. He managed to support Resident 1's head, preventing it from touching the floor.On December 19, 2025, at 3:13 p.m., during a telephone interview, CNA 1 stated if the shower gurney's brakes are not locking very well, she should not have used it and should have reported the issue to the charge nurse.On December 23, 2025, at 10:17 a.m., during a telephone interview, the Director of Nursing (DON) stated that staff are expected to notify her immediately when equipment is not functioning. The DON emphasized that if staff were aware that equipment is malfunctioning and continue to use it, it is unacceptable. They were instructed to remove the equipment from service and inform her promptly.On December 23, 2025, at 2:21 p.m., during a telephone interview, the DON stated she was not aware that the brake of the shower gurney used for Resident 1 was not working properly, as it was not mentioned by the CNA (CNA 1) during investigation. The DON stated the CNA (CNA 1), and the RT (RT 1) should have informed her when the shower gurney's brakes were not locking properly and should have not brought the shower gurney into the resident's room.A review of the facility's policy and procedure titled, Reporting Medical Equipment problems, Failures and User Errors, dated April 2021 indicated, .Procedure for Reporting Equipment Failures .frequency .whenever medical equipment is known or suspected to malfunction or have defect .scope of equipment .all fixed or portable equipment used for diagnoses, treatment, monitoring and care of patients .essential steps .if any of the following conditions exists, remove equipment from service to designated area .switches, knobs or controls that are broken or loose .that do not consistently produce expected results .