

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER San Jacinto Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 275 North San Jacinto Street 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240</p> <p>Based on observation, interview, and record review, the facility failed to ensure for one of two residents, Resident 1, a medication ordered by the doctor was given as prescribed.</p> <p>This failure had the potential for Resident 1 to have hypokalemia (low potassium level in the blood) which could cause Resident 1 to experience muscle cramps and abnormal heart rhythms.</p> <p>Findings:</p> <p>On January 22, 2024, at 9:28 a.m., at the north unit of the facility, a med pass (administration of medications) observation was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 prepared Resident 1 ' s medications which included potassium chloride. LVN 1 placed the box of potassium chloride oral packets, which were labeled for Resident 1 and dated October 24, 2024, on top of the medication cart. LVN 1 removed one oral potassium chloride packet from the box, prepared it, and administered it to Resident 1.</p> <p>A review of Resident 1 ' s medical record indicated she was admitted to the facility on [DATE], with diagnoses which included stroke with right sided weakness.</p> <p>A review of Resident 1 ' s physician ' s orders indicated .Potassium Chloride Oral Packet 20 MEQ (mEq-milliequivalent, a unit of measurement used to express number of electrolytes and medications) .Give 20 mEq by mouth one time a day for hypokalemia admin (administer) it with food/snack and full glass of water or other juices . was ordered on July 16, 2024.</p> <p>On January 22, 2024, at 10:00 a.m., during an interview with LVN 1, LVN 1 was asked to retrieve the box of potassium chloride packets for Resident 1. LVN 1 stated the box indicated it had 30 packets inside, it was opened on October 24, 2024. LVN 1 was asked to count how many packets were still in the box, LVN 1 stated there were 15 packets in the box. LVN 1 stated all of the packets should have been used by at least November 23, 2024. LVN 1 stated maybe Resident 1 refused the medication even before it was prepared for her, with the other licensed nurses.</p> <p>On January 22, 2024, at 10:10 a.m., a review of Resident 1 ' s Medication Administration Record for October and November 2024 was conducted with LVN 1. There was no documented evidence that Resident 1 refused potassium chloride packets in October and November 2024. LVN 1 stated the potassium chloride oral packets were administered to Resident 1 in October and November 2024.</p> <p>(continued on next page)</p>

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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 23, 2024, at 4:15 p.m., during an interview, LVN 2 stated there were no other residents who were on potassium chloride oral packets in the north unit.</p> <p>On January 27, 2025, at 2:55 p.m., during a telephone interview with the Director of Nursing (DON), the DON stated she assumed Resident 1 ' s potassium chloride oral packets were not given as ordered. The DON stated the box of potassium chloride packets that was opened on October 24, 2024, should have already been empty, and that she expected the licensed nurses to administer the medications as ordered. The DON further stated if Resident 1 was not given her potassium chloride, she could have hypokalemia.</p> <p>A review of the facility ' s policy and procedure titled, Administering Medications, dated 2001, indicated . Medications are administered in a safe and timely manner .in accordance with prescriber orders .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48240</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection prevention protocols were implemented, for two of two residents, Residents 1 and 2, when a facility staff member did not perform hand hygiene in between residents ' care, and did not disinfect the automatic blood pressure cuff (BP cuff) before and after residents ' use.</p> <p>These failures had the potential for the vulnerable residents to be exposed to cross-contamination and the development of infections.</p> <p>Findings:</p> <p>On January 22, 2024, at 9:24 a.m., a medication pass was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 carried an automatic BP cuff machine from the top of the medication cart and went to Resident 1 ' s room. LVN 1 applied the BP cuff to Resident 1 ' s left wrist. After obtaining Resident 1 ' s BP reading, LVN 1 removed the automatic BP cuff from Resident 1 ' s wrist and place it on top of the medication cart. LVN 1 did not perform hand hygiene and did not disinfect the automatic BP cuff machine after use on Resident 1.</p> <p>LVN 1 prepared Resident 1 ' s medications, went back to Resident 1 and administered the medications. LVN 1 did not perform hand hygiene after preparing the medications and after administration of Resident 1 ' s medications.</p> <p>During the same medication pass observation, LVN 1 was observed taking the same BP machine from the top of the medication cart and go to Resident 2 ' s room. LVN 1 applied the BP machine on Resident 2 ' s left wrist. LVN 1 removed the BP machine from Resident 2 after obtaining Resident 2's BP reading. LVN 1 placed the BP machine on top of the medication cart. LVN 1 did not disinfect the BP machine and did not perform hand hygiene.</p> <p>LVN 1 prepared Resident 2 ' s medications and went back to Resident 2 and administered the medications. LVN 1 did not perform hand hygiene after preparing the medications and after administration of Resident 2 ' s medications.</p> <p>On January 22, 2024, at 10:00 a.m., during an interview, LVN 1 stated hand hygiene should be performed in between residents. LVN 1 stated she did not perform hand hygiene before and after preparing and after administering medications for Residents 1 and 2. LVN 1 stated she did not know that she had to perform hand hygiene before and after preparing medications. LVN 1 stated she should have performed hand hygiene in between Resident 1 and Resident 2. LVN 1 stated the BP cuff should be disinfected between residents ' use. LVN 1 stated she did not disinfect the BP cuff after using it on Resident 1. LVN 1 stated she should have disinfected the BP cuff after using it on Resident 1.</p> <p>On January 23, 2024, at 2:32 p.m., during an interview, the Director of Nursing (DON) stated hand hygiene and disinfection of the BP cuff should be performed between provision of care of residents, as this can lead to a possible spread of infection.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s undated policy and procedure titled, Policy and Procedures for Med Pass indicated . Cleanse hands before handling medication and before contact with resident .</p> <p>A review of the facility ' s policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment dated 2001 indicated .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the current CDC (Centers for Disease Control and Prevention- a nationally recognized disease control and prevention organization) recommendations for disinfection .Non-critical items are those that come in contact with intact skin but not mucous membrane . Non-critical resident-care items include .blood pressure cuffs .</p> <p>According to the CDC article titled, Disinfection and Sterilization Guideline for Disinfection and Sterilization in Healthcare Facilities, dated June 2024, .non-critical patient-care devices are disinfected when visibly soiled and on a regular basis .such as after use on each patient .</p>