STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055223	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Jacinto Valley Post Acute	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an exit door (EXD 1), located along (name of street), was readily accessible and unobstructed for 24 of 24 residents when the door handles were secured with a zip tie.This failure resulted in an obstructed exit door and had the potential to result in a delay or prevent the residents from exiting the facility during an emergency, such as a fire.Findings:On April 14, 2026, at 10:07 a.m., during a concurrent observation and interview, Resident 1 was awake and alert, sitting in his wheelchair near EXD 1. Resident 1 stated EXD 1 used to be the main entrance. Resident 1 stated he observed EXD 1 door handles were zip tied on two separate occasions. Resident 1 stated on the first occurrence, the door handles were secured with three zip ties; he could not remember when. The second occurrence was two days ago, when a black zip tie was on the door handles, which was later removed by a maintenance staff. Resident 1 stated they are not supposed to zip tie EXD 1 because if there is an emergency they cannot get out.On April 14, 2026, at 1:30 p.m., during a concurrent observation and interview, Resident 2 was awake and alert, sitting in his wheelchair near EXD 1. Resident 2 stated EXD 1 was zip tied on two occasions; approximately one or two weeks ago and again on April 12, 2026, at 7:15 p.m. Resident 2 stated he took a photograph of EXD 1 on April 12, 2026. Resident 2 stated when EXD 1 was zip tied, it made him feel like it was not a safe situation if there was a fire; the only way to remove the zip tie is to cut it.On April 14, 2026, at 1:54 p.m., during a concurrent interview and observation of the facility's exit doors (EXDs), the Maintenance Director (MTD) stated they check the EXDs weekly to make sure they are working properly and are unobstructed, so that egress (exit) is easy and there are no delays if an emergency occurs.On April 14, 2026, at 2:33 p.m., during a concurrent interview and review of the photograph of EXD 1, received by the California Department of Public Health, with the MTD and Maintenance Assistant (MA) 1, the MTD stated the photograph is the facility's lobby area showing EXD 1, and the door was zip tied and it should not be zip tied. During the same interview, the Administrator (ADM) joined and he was shown the same photo. The ADM stated a night shift (11 p.m. to 7 a.m.) staff member decided to zip tie EXD 1 because they were concerned that residents may exit through that door, but that is not their policy. The ADM stated EXD 1 was zip tied one week ago and was identified again on Monday, (April 13, 2026). The ADM further stated a zip tie is not a lock and can be removed easily. The MTD and MA 1 both stated that the zip tie can be undone by forcing the doors to open. The MTD stated when EXD 1 was zip tied, it could lead to a delayed egress.On April 14, 2026, at 4:15 p.m., during an interview, the Director of Nursing stated that the MTD notified her on April 13, 2026, at 8:53 a.m. that EXD 1 was zip tied and it was removed right away. On April 15, 2026, at 1:05 p.m., during a telephone interview, the Registered Nurse (RN) stated EXD 1 used to be the main entrance, and it always had an alarm. The RN stated all the EXDs are closed and have two alarms each and anyone can exit those doors anytime but cannot come back inside. The RN stated on April 12, 2026, he was the RN for the PM (3 p.m. to 11 p.m.) shift, and during dinner time, he noticed a food delivery driver was already inside the facility near EXD 1. The RN stated he then noticed that the gate outside EXD 1 was wide open and they did not hear the alarm go off. The RN stated he and a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Certified Nurse Assistant (CNA) checked on EXD 1 and the alarm was deactivated. The RN stated he tried to set the alarm, but he did not know how, as the alarm was new. The RN stated as an immediate solution for safety, he placed a black zip tie on the door handles of EXD 1. The RN stated he usually calls MA 2, who is the on-call maintenance staff, when there is something in the facility that needs to be fixed, but he forgot because he was doing two admissions that night. The RN stated exit doors should be accessible in case of an emergency.A review of Resident 1's admission Record (AR) dated April 14, 2026, indicated he was admitted to the facility on [DATE], with diagnoses which included transient ischemic attack (a temporary blockage of blood flow to the brain).A review of Resident 1's History and Physical (H&P) dated August 22, 2025, indicated he has the capacity to understand and make decisions.A review of Resident 2's AR dated April 14, 2025, indicated he was admitted to the facility March 14, 2025, with diagnoses which included paraplegia (the partial or complete paralysis of the lower half of the body, typically affecting both legs and sometimes part of the trunk).A review of Resident 2's H&P dated November 12, 2025, indicated he has the capacity to understand and make decisions.A review of the facility's policy and procedure titled Exits or Means of Egress dated July 2024 indicated, .The facility has emergency exits for rapid evacuation .exit doors remain unlocked at all times .