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 11/08/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47832 Based on observation, interview, and record review, the facility failed to ensure for one of four residents reviewed for urinary catheter (tube inserted into the bladder to drain urine), the urinary catheter drainage bag was covered with a dignity bag (a bag that covers and holds a catheter drainage to keep it out of sight). This failure resulted in violation of Resident 37's rights to be treated with dignity and respect. Findings: On November 4, 2024, at 10:17 a.m., Resident 37 was observed with the urinary catheter drainage bag not covered with a dignity bag. On November 4, 2024, at 10:20 a.m., during an interview with Certified Nursing Assistant (CNA) 1, she stated there should be a dignity bag over the urinary catheter drainage bag. CNA 1 stated not covering the drainage bag could cause embarrassment to the resident. On November 4, 2024, at 10:25 a.m., during an interview with the Licensed Vocational Nurse (LVN) 1, she stated the dignity bag should be placed over the urinary catheter drainage bag. LVN 1 stated the policy of the facility was to place a dignity bag over the urinary catheter drainage bag. On November 7, 2024, at 2:40 p.m., during an interview with the Director of Nursing (DON), she stated it was the facility policy to cover the urinary catheter drainage bag to provide dignity and respect to the resident. A review of Resident 37's admission record indicated Resident 37 was admitted to the facility on [DATE], with diagnoses which included Type 2 diabetes (chronic disease that occurs when the body does not use insulin properly), benign prostatic hyperplasia (BPH - enlarged prostate gland), hypertension (high blood pressure), and cerebrovascular accident (occurs when blood flow to the brain is suddenly cut off). A review of Resident 37's Minimum Data Set (MDS - a standardized comprehensive assessment and care planning tool), dated October 3, 2024, indicated Resident 37 had a BIMS (Brief Interview for Mental Status - a tool used to screen and identify cognitive condition of residents) score of 12 (moderate cognitive impairment). (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: 055223	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/08/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 37's physician orders dated September 27, 2024, indicated to change urinary catheter bag every 14 days for urinary retention secondary to BPH. A review of the facility's policy and procedure titled, Dignity, revised February 2021 indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: helping the resident to keep urinary catheter bags covered .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to ensure the care plan for the care of resident's surgical site and left hip dressing was initiated and developed for one of 19 residents reviewed (Resident 141). This failure had the potential for Resident 141 not to receive the necessary care and services if the surgical site developed infection and/or the resident experienced other complications. Findings: On November 4, 2024, at 12:15 p.m., Resident 141 was observed awake, alert, lying in bed. Resident 141 stated she fell at home and broke her left hip. She stated she had left hip surgery. Resident 141 stated the surgeon applied a special type of dressing and it should not be removed for seven days. On November 5, 2024, a record review was conducted for Resident 141. Resident 141 was admitted to the facility on [DATE], with diagnoses which included fracture of the left hip. The history and physical (H&P) indicated Resident 141 had the capacity to understand and make decisions. The physician's order dated November 1, 2024, indicated, .L (left) Hip Aquacel Dressing (a type of dressing that provides a moist environment that supports the growth of new blood vessels) .do not change for 7 days . The facility's document titled, NURSING-ADMISSION/READMISSION EVALUATION ASSESSMENT, dated October 31, 2024, indicated, .L (left) hip surgical incision . The nurse's notes from October 31, 2024 to November 5, 2024, were reviewed. There was no documented evidence the surgical site was assessed and monitored. There was no documented evidence the care plan was initiated and developed for the care of the left hip dressing and the surgical site. On November 6, 2024, at 9:45 a.m., a concurrent interview and record review was conducted with the Registered Nurse Supervisor (RNS) 1. RNS 1 stated Resident 141 was admitted with the left hip dressing and acknowledged the physician's order not to be removed for seven days. RNS 1 stated a care plan for Resident 141's aquacel left hip dressing should have been initiated and developed to monitor the integrity of the surgical site and the dressing. She stated the licensed nurse who performed the admission assessment for Resident 141 should have developed the care plan. A review of the facility's policy and procedure titled, Care Plans, dated April 2009, indicated, .Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level .care plan goals and objectives are derived from information contained in the resident's comprehensive assessment .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for two (Residents 45 and 12) of 19 residents reviewed, when: 1. For Resident 45, one opened tube of Voltaren cream (medication used to treat arthritis pain) and one opened bottle of Magnesium Ashwagandha tablets (a medication that supports mental health and sleep) were observed on top of the resident's bedside table; and 2. For Resident 12, one opened bottle of Calcium Carbonate (medication used to relieve heartburn, acid indigestion, and stomach upset) was observed on top of the resident's bedside table. These failures had the potential for Residents 45 and 12 to receive medications without a physician's order. Findings: 1. On November 4, 2024, at 11:46 a.m., Resident 45 was observed lying in bed. One opened tube of Voltaren cream and one opened bottle of Magnesium Ashwagandha tablets were observed on top of Resident 45's bedside table. During a concurrent interview with Resident 45, she stated the staff were aware she was using the Voltaren cream and the Magnesium Ashwagandha tablet. She stated she would apply the Voltaren cream to her right hip and right leg daily to treat her pain. On November 6, 2024, at 10:34 a.m., Resident 45 was observed with LVN (Licensed Vocational Nurse) 1. Resident 45 was observed lying in bed. Two tubes of Voltaren cream (one opened tube and one unopened tube) and one opened bottle of Magnesium Ashwagandha tablets were observed on top of Resident 45's bedside table. Resident 45 stated she was taking the Magnesium Ashwagandha tablet once a day for one and a half months. Resident 45 also stated she applied the Voltaren cream to her right hip and right leg once a day to treat her pain. In a concurrent interview with LVN 1, she stated medications were not allowed to be left at the resident's bedside. She stated Resident 45 did not have a physician's order for the Voltaren cream and the Magnesium Ashwagandha . She also stated the residents were not allowed to self-administer a medication without a physician's order. She stated medications from home should be verified with the physician and if ordered, the resident will receive the medications dispensed by the facility pharmacy. Resident 45's record was reviewed. Resident 45 was admitted to the facility on [DATE], with diagnoses which included muscle spasms and lower back pain. A review of the history and physical dated July 16, 2024, indicated Resident 45 did not have the capacity to understand and make decisions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On November 4, 2024, at 3:03 p.m., Resident 12 was observed in the room sitting in the wheelchair. One opened bottle of calcium carbonate tablets was observed on top of Resident 12's bedside table. During a concurrent interview with Resident 12, he stated he was taking one tablet of calcium carbonate tablet daily to prevent heartburn. On November 6, 2024, at 11:05 a.m., Resident 12 was observed with LVN 2. One opened bottle of calcium carbonate was observed on top of Resident 12's bedside table. In a concurrent interview with LVN 2, she stated residents were not allowed to keep home medications at bedside and there should be a screening for medication self-administration. Resident 12's record was reviewed. Resident 12 was admitted to the facility on [DATE], with diagnoses which included gastroesophageal reflux disease (GERD - acid reflux). A review of Resident 12's medication self-administration safety screen dated March 20, 2019, indicated all medications will be administered by licensed nurse staff. On November 6, 2024, at 11:10 a.m., during an interview with Registered Nurse Supervisor (RNS) 2, he stated the residents were not allowed to keep their own medications at bedside. He also stated when a family member brought in a medication, the staff should call the physician for an order and the staff will only administer medications dispensed by the facility pharmacy. On November 6, 2024, at 11:20 a.m., during an interview with the Director of Nursing (DON), she stated the residents were not allowed to have medications left at bedside. She stated there should be a resident assessment for medication self-administration. She also stated when a family brought in medication from home or the hospital, the staff should verify the medication with the resident's physician and if ordered, the medication will be sent home with the family and removed from the resident's bedside. She stated the facility will provide all resident medications ordered by the physician. The facility policy and procedure titled, ADMINISTERING MEDICATIONS, dated, April 2019, indicated, . Medications are administered in accordance with prescriber orders .Residents may administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely . The facility policy and procedure titled, STORAGE OF MEDICATIONS, dated, April 2007, indicated, .Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems . The facility policy and procedure titled, SELF-ADMINISTRATION OF MEDICATIONS, revised February 2021, indicated, .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to ensure for one of 19 residents (Resident 66) reviewed who smoked in the facility did not have a lighter in her possession. This failure had the potential to result in injury or accident related to unsupervised smoking. Findings: On November 14, 2024, at 10:54 a.m., during a concurrent observation and interview with Resident 66, Resident 66 was brought back to her room in a wheelchair by a facility staff. Resident 66 stated she smokes four times a day and just came back from the smoking patio. Resident 66 stated she was allowed to keep her smoking materials with her and pulled out a pack of cigarettes and a lighter from her pocket. An oxygen concentrator (a machine that supplies oxygen) was observed at Resident 66's bedside. Resident 66 stated she used oxygen during the night. Resident 66 stated she was aware not to smoke in her room. On November 6, 2024, at 12:15 p.m., during an interview with the Activities Director (AD), the AD stated the residents were allowed to keep their cigarettes but not the lighter at bedside. The AD stated she was aware Resident 66 had a lighter in her possession and did not want to give it up. She stated Resident 66's lighter had been confiscated before and was not sure how she got a new one. The AD stated there was a safety issue with Resident 66 having an oxygen concentrator at the bedside and a lighter in her possession. On November 6, 2024, at 12:20 p.m., during an interview with Registered Nurse Supervisor (RNS) 1, she stated the residents were not allowed to keep smoking materials at bedside. She stated Resident 66's lighter had been previously confiscated and she was not aware the resident had a lighter in her possession. On November 6, 2024, at 12:28 p.m., during an interview with the Director of Nursing (DON), she stated the activity department should keep all the smoking materials. The DON stated the residents were not allowed to keep their smoking materials for safety reasons. Resident 66's record was reviewed. Resident 66 was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure, hypertension (high blood pressure) and schizophrenia (a mental illness that is characterized by disturbances in thought). The history and physical dated September 11, 2024, indicated Resident 66 had intermittent (not continuous or steady) capacity to make decisions. The care plan dated June 25, 2024, indicated, .Resident is a smoker and is at risk for smoking related injury as evidenced by poor safety awareness .All matches and lighters will be kept in the activity office . Interventions .Smoking paraphernalia will be stored per facility guidelines . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The undated facility policy and procedure titled, SMOKING POLICY, indicated, .No lighting materials (e.g. matches, lighters), tobacco products, or smoking devices will be allowed to be kept in the possession of the residents .All smoking materials will be retained by staff .The facility reserves the right to immediately confiscate smoking materials .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39920 Based on observation, interview, and record review, the facility failed to ensure expired food items were not stored in the refrigerator, readily available for use. This failure had the potential to result in foodborne illness to an already vulnerable facility population. Findings: On [DATE], at 9:55 a.m., an initial tour of the kitchen was conducted with the Dietary Supervisor (DS). A one gallon size pitcher of water, that was almost full, dated [DATE], was observed in the refrigerator, readily available for use. In a concurrent interview, the DS stated the water was used for residents who preferred cold water and [DATE] was the use-by-date. The DS stated the water should have been discarded on or before the use-by-date. Additionally, a one-gallon pitcher with a thickened liquid, approximately a quarter-full, dated [DATE], was observed in the refrigerator, readily available for use. In a concurrent interview, the DS stated the liquid in the pitcher was used for residents who are on a diet with thick liquids and [DATE] was the use-by-date. The DS stated the thickener should have been discarded on or before the use-by-date and not stored in the refrigerator, readily available for use. The facility policy and procedure, titled, Storage of Food and Supplies, revised 2020, was reviewed. The policy and procedure indicated, .Food and supplies will be stored properly and in a safe manner .

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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** 29623 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were implemented for three of 19 residents reviewed (Residents 69, 86, and 140) when: 1. For Resident 69, the hand held nebulizer mouthpiece (a device that contains medication that turns into a mist) was left exposed on top of the bedside table near the resident's urinal; 2. For Resident 86, the Enhanced Barrier Precaution (EBP - infection control practices that use gowns and gloves to reduce the spread of multidrug-resistant organisms) was not followed when the resident was admitted with the colostomy (an operation in which a piece of the colon is diverted to an artificial opening in the abdomen that allows stool to pass through); and 3. For Resident 140, the Physical Therapy Assistant (PTA) was not wearing a gown when performing physical therapy exercises at the resident's bedside. Resident 140 was identified for EBP. These failures had the potential to increase the risk for cross contamination and the development of infection from staff to vulnerable residents. Findings: 1. On November 4, 2024, at 12:50 p.m., Resident 69 was observed awake, alert, sitting up at the edge of his bed with oxygen on at 5Liters/minute through nasal cannula (a plastic tubing with two prongs used to deliver oxygen through the nose). Resident 69 stated he was short of breath this morning, and had to use the hand held nebulizer for his breathing treatment. The hand held nebulizer mouth piece attached to a plastic tubing was observed on top of the resident's bedside table close to his urinal. On November 4, 2024, at 1:10 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated the hand held nebulizer should be kept inside the plastic bag when not in use and should not be left above the bedside table next to the urinal. She stated Resident 69 was at risk for infection. On November 5, 2024, a review of Resident 69's record indicated Resident 69 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - a lung disease). The physician's order dated October 27, 2024, indicated Resident 69 had an order for Albuterol Sulfate (a medication used for breathing treatment) 2.5milligram (mg- a unit of measurement) per 3 milliliter (ml), 1 inhalation via (through) nebulizer every 4 hours as needed for SOB/Dyspnea (shortness of breath/difficulty of breathing). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 8, 2024, at 10:20 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the hand held nebulizer should be kept inside the plastic bag after use to prevent infection. She stated licensed staff who administered the nebulizer treatment for Resident 69 should have placed the nebulizer kit inside the plastic bag after cleaning. On November 8, 2024, at 12:25 p.m., an interview was conducted with the Infection Preventionist (IP). The IP stated the hand held nebulizer mouth piece should not be on top of the bedside table, and the urinal should be kept at the urinal holder. The IP stated the hand held nebulizer should be kept inside the plastic bag after use to prevent cross contamination and infection. A review of the facility's policy and procedure titled, Prevention of Infection Respiratory Equipment, dated November 2011, indicated.Infection Control Considerations Related to Medication nebulizers .Store the circuit in plastic bag, marked with date, and resident's name . 2. On November 4, 2024, at 12:25 p.m., Resident 86 was observed awake, lying in bed, alert and able to verbalize her needs. Resident 86 stated she had diarrhea at home for 3 weeks, and she lived alone, was getting weak and she called 911. She stated she had an emergency surgery for her bowel and had a colostomy. Resident 86 voluntarily pulled her shirt and showed her left colostomy. She stated the nurse changes the bag and the certified nursing assistant (CNA) would empty the stool from the bag. She stated it might be temporary and the surgeon might reverse it later. The colostomy bag was observed with brownish stool. Resident 86's room had no designated EBP sign and there was no Personal Protective Equipment (PPE - protective clothing, gloves, faceshields, goggles, facemasks and/or respirator designed to protect the wearer from tyhe spread of infection or illnesses) cart outside the room. On November 4, 2024, at 1p.m., Resident 86's room was observed without the EBP signage and PPE outside the door. On November 4, at 1:30 p.m., a concurrent observation and interview was conducted with the Infection Preventionist (IP) nurse. The IP stated Resident 86 should be on EBP on admission for her colostomy. The IP acknowledged Resident 86 had a bowel surgery and EBP should have been implemented to avoid cross contamination. On November 6, 2024, a review of Resident 86's record indicated Resident 86 was admitted to the facility on [DATE], with diagnoses which included diverticulitis of the intestines (inflammation or infection of small pockets on the inside of the colon). Resident 86 was at the acute facility on September 29, 2024, for large bowel obstruction and repair of the colovesicular fistula (an abnormal connection between the colon and urinary bladder) and a colostomy. The facility's admission assessment on October 12, 2024, indicated Resident 86 was admitted with a colostomy on the left lower area of her abdomen. The physician's history and physical dated October 13, 2024, indicated Resident 86 had the capacity to understand and make decisions. The care plan indicated Ostomy (opening)- Bowel: Resident has ileostomy and is at risk for complications . Observe signs and symptoms of complications .ostomy care . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 8, 2024, at 10:15 a.m., an interview was conducted with the DON. The DON stated the licensed nurse who admitted Resident 86 on October 12, 2024, should have identified and placed the resident on EBP to avoid cross contamination and spread of infection. A review of the facility policy and procedure titled, Isolation - Categories of Transmission-Based Precautions, dated September 2022, indicated, .Enhanced Standard precautions . The facility will follow the current guidance .Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk .contamination of staff hands, clothes, and the environment such as .device care . 3. On November 4, 2024, at 11:10 a.m., Resident 140 was observed with Enhanced Barrier Precaution (EBP) signage outside his room, and a cart containing the PPE. The PTA was observed at the bedside assisting Resident 140 with upper and lower exercises. The PTA was observed having direct contact with the resident, and was not wearing the disposable gown. Resident 140 was sitting at the edge of the bed with the indwelling urinary catheter (a flexible tube inserted into the bladder to drain urine). On November 4, 2024, at 11:20 a.m the PTA was interviewed. He stated he just realized Resident 140 was on EBP for the indwelling urinary catheter. He stated he came in fast in the room without looking at the sign outside the residents' room. He stated he should have followed the EBP process. On November 4, 2024, at 11:45 a.m., an interview was conducted with RN Supervisor (RNS) 1. RNS 1 stated the PTA should have followed the EBP protocol. She acknowledged PTA was not wearing the disposable gown when having direct contact with Resident 140. On November 5, 2024, Resident 140's record was reviewed. Resident 140 was admitted to the facility on [DATE], with diagnoses which included history of falling, benign prostatic hypertrophy (BPH - enlarged prostate), and retention of urine. The physician's history and physical indicated Resident 140 had an indwelling urinary catheter in place. A Physician order indicated, .Observed Enhanced Barrier Precaution (EBP) Resident has Indwelling Foley Catheter for Urinary Retention due to Obstructive Uropathy Related to BPH every shift . On November 7, 2024, at 10:01 a.m., The DON was interviewed. The DON stated the PTA should have checked the EBP sign before entering Resident 140's room. On November 7, 2024, at 12:18 p.m., the IP was interviewed. She stated the PTA should have looked at the EBP sign at the door. The PTA should have donned (put on) the disposable gown prior to entering the room. A review of facility's policy and procedure titled Isolation- Categories of Transmission - Based Precautions, dated September 2022, indicated, .The facility will follow current guidance .regarding Enhanced Standard Precaution .Wear gowns and gloves while performing the high-contact tasks associated with the greatest risk .any care activity where close contact with the resident is expected to occur .