

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/30/2026
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)		
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 implement, review, and re-evaluate care plan interventions to prevent falls two of 19 residents reviewed (Resident 20 and Resident 86). This failure resulted in Resident 20 and Resident 86 experiencing multiple falls and had the potential for Resident 20 and Resident 86 to sustain avoidable injuries. Findings: On January 26, 2026, at 3:59 p.m., a concurrent observation and interview was conducted with Resident 20. Resident 20 was observed alert and oriented, in a low bed with floor mat, receiving gastrostomy (medical device inserted into the stomach for administering formula, fluids, and medication) feeding. Resident 20 stated he fell out of bed attempting to go to the restroom. Resident 20's medical record was reviewed. Resident 20 was admitted into the facility on July 21, 2025, with diagnoses which included muscle weakness, gastrotomy, and encephalopathy (brain dysfunction). The history and physical dated July 22, 2025, indicated Resident 20 did not have the capacity to understand and make decisions. The BIMS (Brief Interview for Mental Status- an assessment tool) dated October 28, 2025, indicated a score of 9 (meaning moderate thinking impairment). The change of condition note for the following dates December 28, 2025; January 5, 2026; and January 20, 2026, indicated Resident 20 experienced three falls within 23 days. The care plan dated December 30, 2025, indicated .Falls: Resident had an unwitnessed fall and is at risk for fear of falls, injury, recurring falls .Intervention .Anticipate and meet needs .Keep bed in low position with brakes locked .Keep call light within reach .Keep personal items frequently used within reach .Medication regimen review as indicated . There was no documented evidence in Resident 20's medical record that the medication regimen review was conducted as indicated in the care plan intervention dated December 30, 2025. The care plan dated January 20, 2026, indicated .Falls: resident had an unwitnessed fall on 1/20/2026 .interventions .Anticipate and meet needs .Educate/remind resident to call for assistance .Evaluation of medications for side effects that may increase fall risk .Keep bed in low position with brakes locked .Keep call light within reach .Keep personal items frequently used within reach .Medication regimen review as indicated .There was no documented evidence in Resident 20's medical records that a medication regimen review was conducted as indicated in the care plan intervention dated January 20, 2026. There was no documented evidence in Resident 20's medical record that the care plan interventions had been reviewed and updated by the Intradisciplinary Team (a group of professionals from diverse fields who work together collaboratively and independently to achieve a common goal) for effectiveness since Resident 20 experienced three falls within 23 days. On January 28, 2026, at 9:40 a.m., Resident 86 was observed sitting in a wheelchair next to his bed. The bed was observed in a low position with floor mats next to it. Resident 86 was able to respond to introductions but was not interviewable. On January 28, 2026, at 9:44 a.m., an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated she was Resident 86's assigned CNA. CNA 1 stated Resident 86 was a fall risk resident. Resident 86's medical record was reviewed. Resident 86 was admitted to the facility on [DATE], with diagnoses which included left femur fracture healing (healing thigh bone fracture), history of falls, cerebral infarction (brain injury) and dementia (loss of intellectual (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	function).The history and physical dated December 4, 2025, indicated Resident 86 had intermittent (occasional) capacity to make decisions.The BIMS dated December 9, 2025, indicated score of 0 (resident is rarely/never understood).The change of condition notes for the following dates December 12, 2025; December 28, 2025; December 29, 2025; December 31, 2025; and January 25, 2026, indicated Resident 86 experienced five falls within 44 days.Resident 86's care plan was reviewed. There was no documented evidence of a care plan update for the falls dated December 12, 2025, and December 31, 2025.Resident 86's Intradisciplinary Team (IDT) notes were reviewed. There was no documented evidence that an IDT meeting was conducted for the falls dated December 12, 2025; December 31, 2025; and January 25, 2026.On January 29, 2026, at 9:48 a.m., an interview was conducted with CNA 2. CNA 2 stated Resident 20 was a fall risk resident. CNA 2 stated Resident 20 had several falls attempting to get out of bed.On January 29, 2026, at 9:56 a.m., a concurrent interview and record was conducted with the Registered Nurse (RN). The RN stated the facility's process for falls was to assess the resident, notify the physician and the family, execute physician orders, develop a care plan and conduct an IDT meeting. The RN stated Resident 20 was at risk falls. The RN stated the change of condition notes indicated Resident 20 had three falls on the following dates December 28, 2025, January 5, 2026, and January 20, 2026. The RN stated there was no documented evidence of a medication regimen review as indicated in the care plan intervention dated December 30, 2025, and January 20, 2026. The RN stated there was no documented evidence that an IDT meeting was held for the fall on January 20, 2026, and there should have been an IDT meeting for that fall.The RN stated Resident 86 was at risk for falls. The RN stated the change of condition notes indicated Resident 86 had five falls on the following dates December 12, 2025; December 28, 2025; December 29, 2025; December 31, 2025; and January 25, 2026. The RN stated there was no documented evidence of an updated care plan for the falls dated December 12, 2025, and December 31, 2025, and there should have been an updated care plan for those falls. The RN stated there was no documented evidence that an IDT meeting was conducted for the falls dated December 12, 2025; December 31, 2025; and January 25, 2026. The RN stated there should have been an IDT meeting for each fall.On January 29, 2026, at 11:01 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 20 is at risk for falls. The DON stated Resident 20 had 3 falls on the following dates December 28, 2025; January 5, 2026; and January 20, 2026. The DON stated there was no documented evidence of a medication regimen review as indicated in the care plan interventions dated December 30, 2025, and January 20, 2026. The DON stated there should have been a medication regimen review conducted for Resident 20. The DON stated there was no documented evidence that an IDT meeting was conducted for the fall dated January 20, 2026, and there should have been an IDT meeting for the fall on January 20,2026.The DON stated Resident 86 was at risk for falls. The DON stated Resident 86 change of condition notes indicated five falls on the following dates December 12, 2025; December 28, 2025; December 29, 2025; December 31, 2025; and January 25, 2026. The DON stated there was no documented evidence of an updated care plan for the falls dated December 12, 2025, and December 31, 2025, and there should have been an updated care plan for the falls dated December 12, 2025, and December 31, 2025, and there should have been an IDT meeting was conducted for the falls dated December 12, 2025; December 31, 2025; and January 25, 2026. The DON stated there should have been an IDT meeting for each fall.A review of the facility policy titled Safety and Supervision of Residents, revised July 2017, indicated .Implementing interventions to reduce accidents and hazards shall include the following: ensuring that interventions are implemented.monitoring the effectiveness of interventions shall include the following: evaluating the effectiveness of interventions; evaluating the effectiveness of new or revised interventions.A review of the facility policy titled Care Plans, Comprehensive Person Centered, dated December 2016, indicated .The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative develops and implements.person -centered care plan for each resident.The interdisciplinary Team must review and update the care plan: when there has been a significant change in the resident's condition.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure provision of safe and effective pharmaceutical services to meet the needs of the residents when: Medications with holding parameters were not administered according to the physician's orders for three of four reviewed residents (Resident 2, 3, and 109) on blood pressure (BP) medications. This failure had the potential to significantly lower blood pressure to cause dizziness, confusion, fainting and a fall. Findings: 1. On January 28, 2026, a review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 2's Care Plan Report, dated October 24, 2025, indicated, Resident has a diagnosis of hypertension (HTN, high blood pressure) and is at risk for chest pain, decreased blood pressure, dizziness, edema (swelling in parts of body). Administer medication as ordered. Monitor blood pressure as ordered and PRN (as needed). Observe for signs and symptoms of abnormal blood pressure and notify physician as needed. A review of Resident 2's physician orders indicated Metoprolol Tartrate (medication for high blood pressure) 50 mg (milligram - unit of measurement) was ordered on December 25, 2025, to be given one tablet by mouth two times a day for hypertension, Hold med (medication) if SBP (systolic blood pressure - top number in a blood pressure reading) is less than 110 or PR (pulse rate) less than 60. Take with food. A review of Resident 2's Medication Administration Record (MAR) for January 2026 indicated metoprolol 50 mg was administered to Resident 2 when the SBP was below 110 on the following date and time:- January 6, 2026, at 0900 (9 a.m.), SBP 108. 2. On January 29, 2026, a review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including hypertension, hyperlipidemia (high cholesterol) and coronary artery disease (heart disease). A review of Resident 3's Care Plan Report, dated January 8, 2026, indicated, .Hypertension. Administer medications as ordered. Notify physician of signs of irregular heart rate. obtain vital signs as indicated. A review of Resident 3's physician orders indicated Lisinopril (medication for high blood pressure) 10 mg was ordered on December 29, 2025, to be given one tablet by mouth one time a day for Hypertension, Hold med if SBP is less than 110 or PRE (PR - pulse rate) less than 65. A review of Resident 3's MAR, dated January 2026, indicated lisinopril 10 mg was administered to Resident 3 when the pulse rate was below 65 on the following dates and times:- January 12, 2026, at 0900 (9 a.m.), pulse 60; and- January 28, 2026, at 0900 (9 a.m.), pulse 63. 3. On January 29, 2026, a review of Resident 109's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including hypertension, atrial fibrillation (irregular heartbeat), and hyperlipidemia. The record also indicated Resident 109 had a previous admission to the facility on August 21, 2023. A review of Resident 109's Care Plan Report, dated August 21, 2024, indicated, .Hypertension. obtain vital signs as indicated. Administer medications as ordered. A review of Resident 109's physician orders, dated January 27, 2026, indicated the following medications:- Losartan potassium (medication for high blood pressure) 50 mg, Give 1 tablet by mouth one time a day for HTN. Hold if SBP <110 or pulse < 65.; and- Metoprolol tartrate 25 mg, Give 1 tablet by mouth one time a day for HTN. Hold if SBP <110 or Pulse < 60. A review of Resident 109's MAR, dated December 2025 and January 2026, indicated Losartan and Metoprolol were administered to Resident 109 when the SBP was below 110 on the following dates and times: For Losartan potassium 50 mg:- December 14, 2025, at 0900 (9 a.m.), SBP 106;- January 17, 2026, at 2100 (9 p.m.), SBP 101;- January 19, 2026, at 0900 (9 a.m.), SBP 98; For Metoprolol tartrate 25 mg:- January 19, 2026, at 0900 (9 a.m.), SBP 98. On January 30, 2026, at 10 a.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON verified the findings for Resident 2, 3 and 109 and confirmed the blood pressure medications were documented as administered on the MARs despite the physician's orders requiring medications to be held when SBP or pulse rate fell below specified parameters. The DON acknowledged the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician orders were not followed and stated the medications should have been held when the residents' SBP or pulse rate were outside of the prescribed holding parameters. A review of the facility's policy and procedures titled Administering Medications, dated April 2019, indicated, .Medications are administered in accordance with prescriber orders.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage of medications in accordance with the facility policy and procedures (P&P) and manufacturer's specifications when: 1. One expired house supply medication (medications kept for general use for residents, rather than dispensed or labeled for a specific resident) was stored in one of two reviewed medication rooms (North Medication Room); and 2. An expired medication was kept in stock in one of five reviewed medication carts (Middle Medication Cart) along with other active medications. These failures had the potential for the residents to receive expired or ineffective medications, which could lead to medication errors and compromised treatment outcomes. Findings: 1. On January 26, 2026, at 2:43 p.m., during an inspection of North Medication Room with Licensed Vocational Nurse (LVN) 1, an expired unopened bottle of glucosamine sulfate (dietary supplement) 750 mg (milligram - unit of measurement) was observed stored in the medication cabinet with other house supply medications. The bottle indicated the manufacturer's expiration date of October 2025. On January 26, 2026, at 2:43 p.m., during a concurrent interview with LVN 1, LVN 1 verified the manufacture's expiration date on the bottle was October 2025. LVN 1 stated expired medications should be stored separately from medications maintained as house supply for potential resident use. LVN 1 stated the facility assigns a nurse each shift to conduct a medication room check as part of daily assigned duties, and the assigned nurse is responsible for completing a quality check of the medication room, including checking expiration dates of house supply medications stored, and signing the assignment log sheet upon completion. LVN 1 further stated any expired medication identified during the medication room check should be placed in a designated medication cabinet in the medication room for proper disposition or discarded into the pharmaceutical waste bin by documenting the medication information in the Medication Disposition Log for Non-controlled Medications logbook located in the medication room. 2. On January 26, 2026, at 3:22 p.m., during an inspection of Middle Medication Cart with LVN 1, an expired, opened, and used vial of acetylcysteine solution (medication used to help thin and loosen mucus in the airway) 20 % (percent - unit of measurement) 30 mL (milliliter - unit of measurement) for inhalation or oral administration was observed stored in the medication cart with other active medications. The vial was observed to contain remaining solutions. The opened date was handwritten on the vial as December 28, 2025, and the manufacture's label on the vial indicated Discard opened container after 96 hours. A review of the pharmacy-affixed label on the vial indicated the medication was dispensed for Resident 97 with directions to inhale 1 mL orally every 4 hours for wheezing, cough; give while awake. A review of Resident 97's Medication Administration Record (MAR), dated December 2025 and January 2026, indicated the acetylcysteine solution was administered to Resident 97 from December 27, 2025, to January 26, 2026. On January 26, 2026, at 3:22 p.m., during a concurrent interview with LVN 1, LVN 1 verified the vial of acetylcysteine solution was opened on December 28, 2025, and confirmed the solution was used and expired, but remained stored in medication cart with other active medications. LVN 1 further confirmed there were no additional acetylcysteine vials available in the medication cart for Resident 97. LVN 1 stated expired medication should have been disposed of in the pharmaceutical waste bin located in the medication room. On January 27, 2026, at 3:38 p.m. during a concurrent interview and record review with Director of Nursing (DON), the DON confirmed the findings and stated expired medications should have been removed from the medication storage area for active medications and disposed of properly. A review of the manufacturer's package inserts (information on how to safely use a drug) for acetylcysteine, dated November 2024, indicated, .Acetylcysteine solution does not contain an antimicrobial agent, and care must be taken to minimize contamination of the sterile solution. store the remaining undiluted portion in a refrigerator and use within 96 hours. A review of the facility's policies and procedures (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(P&P) titled, Storage of Medications, dated November 2020, indicated, .outdated, or deteriorated drugs .are returned to the dispensing pharmacy or destroyed . A review of the facility's P&P titled Administering Medications, dated April 2019, indicated, .The expiration/beyond use date (the date after which a medication that has been opened, mixed, or prepared should no longer be used, as its safety and effectiveness may no longer be guaranteed) on the medication label is checked prior to administering.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food items readily available for use were stored in the freezer with a label of open date or expiration date. This failure had the potential to result in foodborne illness to a vulnerable facility population. Findings: On January 26, 2026, at 1:46 p.m., during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Dietary Supervisor (DS). One whole piece of roast beef (approx. 7 lbs.) was observed in the freezer, readily available for use. The roast beef was observed with no open date, no use-by date, and no expiration date. The DS stated all items stored in the refrigerator or the freezer should have a label of open date, a use-by date, or an expiration date. The DS stated the roast beef should not have been stored in the freezer without a label and it should have been discarded. The facility policy and procedure titled, Labeling and Dating of Foods, dated 2023, was reviewed. The policy and procedure indicated, .All food items in the storeroom, refrigerator, and freezer need to be labeled and dated .		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five sampled residents (Residents 3 and 105) reviewed for unnecessary psychotropic (drug that affects brain activities associated with mental processes and behaviors) medications were free from unnecessary psychotropic medications when: 1. For Resident 3, Mirtazapine (Antidepressant medication used to treat depression) was prescribed with an indication of Depression without physician-documented clinical evidence supporting a diagnosis of depression; and 2. For Resident 105, the physician did not document the clinical rationale for continued use of the as-needed temazepam (a psychotropic medication used for inability to fall asleep) beyond 14 days. This failure had the potential to result in unnecessary use of psychotropic medications, and increased risk for adverse effects, including falls or sedation. Findings: 1. On January 29, 2026, a review of Resident 3's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including dementia (memory loss), anxiety, history of falling, and fracture of right femur (thigh bone). A review of Resident 3's Care Plan Report, dated January 10, 2026, indicated, .Antidepressant (Mirtazapine): Resident requires antidepressant medication related to depression as evidenced by poor oral intake, meal intake of 50 % (percent - unit of measurement) or less. At risk for ASE (adverse side effects - undesired effect of a drug) . A review of Resident 3's physician orders indicated Mirtazapine 15 mg (milligram - unit of measurement) was ordered on January 10, 2026, to be given one tablet by mouth at bedtime for depression m/b (manifested by) meal intake of 50 % or less. A review of Resident 3's Medication Administration Record (MAR), dated January 2026, indicated the mirtazapine was administered to Resident 3 from January 10, 2026, through January 29, 2026, except when refused on January 20 and January 27, 2026. A review of Resident 3's hospital discharge record titled Discharge Medication Reconciliation Order Report, dated December 18, 2025, indicated diagnoses including dementia with agitation and anxiety; depression was not documented. A review of Resident 3's Physician History and Physical, dated December 31, 2025, indicated Resident 3's diagnoses including dementia with agitation and anxiety; depression was not documented. A review of Resident 3's medical record titled SBAR Summary for Provider (Situation, Background, Assessment, and Recommendation - a standardized communication framework nurses use to provide concise, critical resident information to other healthcare professionals), dated January 3, 2026, indicated Resident 3's diagnoses of dementia and anxiety; depression was not documented. A review of Resident 3's medical record titled, Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated January 5, 2026, indicated a brief interview for mental status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3, consistent with severe cognitive impairment. A review of the MDS Section D - Mood, dated January 5, 2026, indicated Resident 3 endorsed symptoms of depressed mood during the resident interview. A review of MDS Section I - Active Diagnoses, dated January 5, 2026, did not indicate an active diagnosis of depression within the previous seven days. A review of Resident 3's Physician Monthly Progress Note dated January 26, 2026, indicated, .Assessment: .Depression on Mirtazapine. which was the first physician progress note documenting depression as a diagnosis in the medical record, following the initiation of mirtazapine. A review of Resident 3's Nurse Practitioner (NP) Notes, dated January 27, 2026, indicated the initial psychiatric evaluation was conducted on by the psychiatric NP on January 13, 2026. The NP's note indicated, .Assessment/Dx (diagnosis): .Dementia. Anxiety. Continue Mirtazapine as ordered by PCP (primary care physician) . On January 30, 2026, at 2:10 p.m., during a phone interview with the psychiatric Nurse Practitioner (NP), the NP stated the resident was receiving mirtazapine at the time of the evaluation. When asked whether signs or symptoms of depression were observed during evaluation session, the NP stated, based on his assessment, (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anxiety-related symptoms stood out. The NP stated mirtazapine was continued because it had already been ordered by the primary care physician and can be used for the treatment of depression or anxiety. On January 30, 2026, at 10 a.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON confirmed no physician documentation supporting a diagnosis of depression was identified prior to the initiation of mirtazapine. On January 30, 2026, at 2:36 p.m., during a phone interview with the Medical Doctor (MD), the MD stated the resident's poor oral intake was due to multiple contributing factors, including dementia, recent GI (gastrointestinal - stomach and intestines) bleeding issue, and sundowning behaviors (increased confusion, anxiety, agitation in individual with dementia), and agreed that sundowning was associated with dementia rather than depression. The MD stated mirtazapine was prescribed in response to poor oral intake and was later determined to be ineffective, prompting the order for megestrol acetate as appetite stimulant. When asked whether nursing documentation, including MDS documentation indicating the resident had a depressed mood, may have contributed to the entry of a depression diagnosis when he prescribed the mirtazapine, the MD acknowledged this may have contributed and stated the diagnosis of depression did not accurately reflect the clinical indication, which should have reflected poor oral intake or appetite stimulation rather than depression. 2. On January 29, 2026, a review of Resident 105's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including insomnia, anxiety, and depression. A review of Resident 105's Care Plan Report, dated January 1, 2026, indicated, .Resident requires hypnotic (sedative) medication related to insomnia m/b (manifested by) inability to sleep. At risk for ASE (adverse side effect) for the use of Temazepam. A review of Resident 105's physician orders indicated temazepam 30mg was ordered on October 30, 2025, to be given one capsule by mouth every 24 hours as needed for insomnia manifested by inability to sleep. This order was renewed on November 27, 2025, and December 12, 2025, each with a duration of 14 days. The temazepam dose was later decreased to 15 mg, with an order to give one capsule by mouth at bedtime as needed for insomnia manifested by inability to sleep for 14 days. This order was renewed on January 1, 2026, and January 15, 2026. A review of Resident 105's Medication Administration Records (MAR), dated November, December 2025 and January 2026, indicated the as-needed temazepam was administered 13 times in November 2025, 25 times in December 2025, and 27 times in January 2026. A review of Resident 105's medical record titled IDT (interdisciplinary) Psychotherapeutic Review, dated November 10, 2025, December 1, 2025, and January 5, 2026, did not indicate documented clinical rationale for continued use of the as-needed temazepam beyond 14 days. On January 30, 2026, at 2 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON confirmed there was no documented rationale for supporting the extended use of the as-needed temazepam beyond 14 days. The DON stated the medication was continued because the resident continued to request temazepam. A review of the facility's policies and procedures (P&P) titled, Psychoactive/Psychotropic Medication Use, undated, indicated: .A Psychotropic medication.include. Antidepressant.Sedative-Hypnotic.Resident will only receive Psychotropic medications when necessary to treat a specifically diagnosed condition that is documented in the medical record.The attending physician and other staff will gather and document information to clarify, as possible, the resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others.The Attending Physician will identify, evaluate, and document, with input from other disciplines and consultants as needed, medical symptoms that may warrant the use of Psychotropic medications.Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following: indication and clinical need for medication.duration.A clinical [review] in conjunction with the interdisciplinary team must evaluate and document the situation, to identify and address any contributing and underlying causes of the acute condition and verify the need for Psychotropic medication.PRN Psychotropic drug orders.are limited to 14 days. If it is appropriate to extend the order beyond 14 days, the Attending Physician or prescribing practitioner shall document the rationale in the medical record and indicate a duration for the PRN order.		

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NAME OF PROVIDER OR SUPPLIER San Jacinto Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 275 North San Jacinto Street Hemet, CA 92543	
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately assess one of 19 residents (Resident 14) reviewed for Minimum Data Set (MDS - an assessment tool) to reflect the resident's status when Resident 14's MDS assessment had a diagnosis of schizophrenia (a mental illness characterized by disturbances in thought process) without a psychiatric evaluation. This failure had the potential for Resident 14 to receive inappropriate care and services. Findings: On January 26, 2026, at 2:52 p.m., Resident 14 was observed lying in bed, awake and alert. Resident 14 stated she was ok and did not want to be bothered. A review of Resident 14's PASRR (Preadmission Screening and Resident Review (PASRR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care), conducted at the General Acute Care Hospital (GACH) on November 3, 2025, prior to facility admission was reviewed. The screening indicated Resident 14 was negative for serious mental illness, intellectual disability, developmental disability, or related conditions. A review of Resident 14's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included schizophrenia. A review of the History and Physical, dated November 18, 2025, indicated Resident 14 did not have the capacity to make decisions. A review of the MDS, Section C: Cognitive Patterns, dated November 12, 2025, indicated a Brief Interview of Mental Status (BIMS - a cognitive assessment tool) score of 12 (moderately impaired cognition). A review of the MDS, Section I: Active Diagnosis, dated November 12, 2025, indicated a diagnosis of schizophrenia. A review of the Care Plan, dated November 18, 2025, indicated, .Focus.Cognitive Impairment.Schizophrenia. A review of the Resident 14's Order Summary, did not indicate the resident was referred to a psychiatrist for evaluation. There was no documented evidence Resident 14 was seen and evaluated by a psychiatrist to support, validate and verify the diagnosis of schizophrenia. On January 30, 2026, at 10:53 a.m., the MDS Coordinator (a licensed nurse in long-term care facilities who assesses, monitors, and documents patient health using a standardized federal tool) was interviewed. She stated the MDS information was based on data collection and assessment or direct observation of the resident. During a concurrent record review of the MDS dated [DATE], with the MDS Coordinator, she stated that based on the MDS data, Resident 14 was awake, alert, and oriented x 3 (a medical phrase meaning a person is aware of their surroundings, and knows their Person [name], Place [location], and Time [date/day/year]. She stated Resident 14 did not have mental illness behavior or signs of schizophrenia. She stated MDS, Section I, indicated Resident 14 had a diagnosis of schizophrenia. She stated she got the information from Resident 14's diagnosis information on the admission Record. She stated there was no psychiatric consult ordered and/or evaluation conducted either from the GACH or from the facility. She stated there should have been a psychiatric evaluation done either from the hospital or the facility to confirm the diagnosis of schizophrenia. She stated the MDS conducted on November 18, 2025, did not accurately reflect Resident 14's mental status. On January 30, 2026, at 12:03 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). She stated there was no psychiatric evaluation conducted for Resident 14 when she was admitted to the facility. She stated the diagnosis for mental illness should have been validated and should have not been coded as schizophrenia unless there was a psychiatric evaluation conducted to confirm the diagnosis. The facility policy and procedure, titled, Comprehensive Assessments, revised October 2023, indicated, .Comprehensive MDS assessments are conducted to assist in developing person-centered care plans. The facility conducts comprehensive, accurate, standardize, reproducible assessments of each resident's functional capacity. The comprehensive assessment process includes direct observation and communication with residents, as well as communication with licensed and non-licensed direct care staff members. Comprehensive assessments are conducted and coordinated by a registered nurse with appropriate participation of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other health professionals on the interdisciplinary team (a group of professional from diverse fields who work together collaboratively and independently to achieve a common goal.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five residents reviewed (Resident 2) was free of unnecessary medications, when pain assessments were not consistently implemented and documented in conjunction with the administration of scheduled narcotic pain medication. This failure resulted in unmonitored medical condition and had the potential for ineffective pain management, unnecessary excessive dosing, and adverse effects for Resident 2. Findings: On January 28, 2026, a review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses including chronic pain syndrome, polyneuropathy (nerve damage causing pain or numbness), multiple sclerosis (a disease affecting the brain and spinal cord), paraplegia (paralysis of the lower body), Parkinson's disease (a neurological disorder affecting movement), spinal stenosis (narrowing of the spaces in spine causing pain), stage 4 pressure ulcer (deep open wound), muscle wasting and atrophy (loss of muscle mass), and acute osteomyelitis (bone infection). A review of Resident 2's Care Plan Report, dated October 24, 2025, indicated .acute on chronic pain as evidenced by: verbalization of pain (generalized, lumbar [lower back], back, R [right] knee), neuropathy (nerve damage leading to pain), muscle spasm (sudden painful contraction of muscle). Ask and assess pain symptoms. Identify frequency, location, quality, onset and manner of expressing pain. Monitor effectiveness of . pain meds (medications). Monitor for pain and provide medication. Notify physician if ineffective. A review of Resident 2's physician orders indicated oxycodone (a controlled medication for pain) 10 mg (milligram - unit of measurement) was ordered on December 25, 2025, to be given one tablet by mouth four times a day for pain management. A review of Resident 2's Medication Administration Record (MAR), dated December 2025 and January 2026, indicated Resident 2 received oxycodone 10 mg from December 1, 2025, through December 21, 2025, and from December 25, 2025, through January 28, 2026. A review of Resident 2's Weights and Vitals Summary, dated December 2025 and January 2026, indicated Resident 2's pain assessment was documented only seven times during December 2025 and once during January 2026, as follows: - December 10, 2025, at 23:10 (11:10 p.m.), pain scale 5;- December 11, 2025, at 00:20 (12:20 a.m.), pain scale 0;- December 12, 2025, at 07:16 (7:16 a.m.), pain scale 0;- December 20, 2025, at 07:38 (7:38 a.m.), pain scale 0;- December 26, 2025, at 07:19 (7:19 a.m.), pain scale 0;- December 27, 2025, at 07:43 (7:43 a.m.), pain scale 0;- December 28, 2025, at 12:14 (12:14 p.m.), pain scale 0; and- January 2, 2026, at 22:33 (11:33 p.m.), pain scale 0. A review of Resident 2's Physical Medicine & Rehab (rehabilitation) Follow-up, dated December 18, 2025, and December 21, 2025, indicated, .Pain management .Monitor for any breakthrough pain (sudden increase in pain) that may interfere with therapy engagement . On January 30, 2026, at 10:18 a.m., during a concurrent interview and record review with Director of Nursing (DON), the DON verified the findings and stated the residents receiving routine scheduled narcotic pain medications require ongoing pain assessment, monitoring, and documentation to evaluate whether pain is adequately controlled, or requires dose adjustment. The DON stated pain assessment should have been performed and documented at least every shift as part of routine nursing assessments, including vital sign checks with pain level assessment, regardless of whether pain medication was ordered on a scheduled or PRN (as needed) basis. The DON further stated due to the resident being admitted , discharged , and readmitted multiple times, the order for every shift pain assessment had fallen out of the system and should have been re-entered. On January 30, 2026, at 2:19 p.m., during a phone interview with the facility's Consultant Pharmacist (CP), the CP stated residents receiving scheduled narcotic pain medications, such as oxycodone, require routine pain assessments to evaluate medication effectiveness and to determine the ongoing need for the medication. A review of the facility's policies and procedures (P&P) titled, Pain Assessment and Management, dated April 2025, indicated: .Ask the resident if he/she is experiencing pain. Assessing Pain. 1. Assess the resident. during ongoing assessments. 2. Monitor the resident for (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the presence (or worsening) of pain.3. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.When opioids are used for pain management, the resident is monitored for medication effectiveness.Monitoring and Modifying Approaches. 1. Monitor the resident's pain and consequences of pain at least each shift for acute or sub-acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. 2. Monitor the resident by performing a basic assessment with enough detail and as needed, with standardized assessment tools (e.g., approved pain scales, etc.) and relevant criteria for measuring pain management (e.g., target signs and symptoms). 3. Monitor the following factors to determine if the resident's pain is being adequately controlled: a. The resident's response to administered pain medications. A review of the facility's P&P titled, Administering Medications, dated April 2019, indicated, .As required or indicated for a medication, the individual administering the medication records in the resident's medical record.any complaints or symptoms for which the drug was administered.Any results achieved and when those results were observed.		