STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555566	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONA POST ACUTE CENTER	**2600 SOUTH MAIN STREET CORONA, CA 92882**

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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** Based on interview and record review, the facility failed to ensure one of two residents reviewed for dignity (Resident 60), was allowed access to the restroom at the lobby and at the nurses' station for This failure had the potential to affect resident's physical, mental, and psychosocial wellbeing. Findings: On March 8, 2020, at 12:05 p.m., Resident 60 was interviewed. The resident stated he was not allowed to use the bathroom outside of his room. Resident 60 stated the staff told him to use the restroom in his room; however, his room was a long walk from the activity room and smoking area. Resident 60 stated sometimes he would pee in his pants since he was taking water pill (pill designed to help body eliminate excess water and salt in the form of urine). On March 11, 2020 at 10:10 a.m., the Activity Assistant (AA) was interviewed. The AA stated the restroom at the lobby was for the guests and for the staff to use. The AA stated she would tell the resident to go to his room if the resident wanted to use the restroom. On March 11, 2020, at 10:14 a.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated the residents had a restroom in their rooms. CNA 1 stated if the resident wanted to use the other restroom he could use it if needed. She stated it was not right for Resident 60 to pee in his pants. CNA 1 stated Resident 60 is alert and oriented and needed limited assistance with toileting. Resident 60's record was reviewed. Resident 60 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], indicated Resident 60 had no cognitive impairment. Resident 60 is always continent of bowel and bladder. On March 11, 2020, at 11:10 a.m., CNA 2 was interviewed. CNA 2 stated the residents have their restrooms in their rooms. CNA 2 stated the residents were not allowed to use the employee's restroom. On March 11, 2020, at 11:13 a.m., Registered Nurse Supervisor (RNS) 1 was interviewed. RNS 1 stated if the resident needed to use the restroom, the resident will be escorted back in their rooms for dignity issue. RNS 1 stated the resident were not allowed to use the restroom at the nurse's station for infection control. On March 11, 2020, at 11:28 a.m., the receptionist was interviewed. The receptionist stated if a resident needed to use the restroom in the lobby, she will tell the resident to go to his room. The receptionist stated the restroom in the lobby was for the guests. On March 11, 2020, at 11:39 a.m., Resident 60 was interviewed. Resident 60 stated he asked the staff a lot of times if he could use the restroom at the lobby and at the nurse's station. Resident 60 stated yesterday afternoon he asked the staff if he could use the restroom, and the staff did not allow him to use the restroom at the nurse's station. Resident 60 stated the staff told him to 'pee in his pamper if he could not make it to his room. On March 11, 2020, at 11:52 a.m., the Director of Staff Development (DSD) was interviewed. The DSD stated resident could use the restroom at the lobby and at the nurse's station depending on the condition of the resident. The DSD stated if the resident is ambulatory there should be no problem. The DSD stated the resident should be allowed to use the restroom at the lobby and at the nurse's station. The policy and procedure titled, Quality of Life - Dignity, dated August 2009, was reviewed. The policy and procedure indicated, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by .Allowing residents unrestricted access to common areas open to the public .
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call lights were within reach for two of two residents (Residents 55 and 101), to call for assistance. This failure had the potential for the residents not being able to call for staff assistance when needed. Findings: 1. On March 8, 2020, at 9:25 a.m., Resident 101 was observed in bed. Resident 101's call light button was observed on the floor. In a concurrent interview, Resident 101 stated her call light button should be on top of her toy bear, for her to use in calling for staff assistance. On March 8, 2020, at 9:28 a.m., Certified Nursing Assistant (CNA) 4 was interviewed. CNA 4 stated she was familiar with Resident 101. CNA 4 stated Resident 101's call light was not within reach. She stated the call light should be within the resident's reach. Resident 101's record was reviewed. Resident 101 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan dated January 16, 2020, indicated, Resident At risk for ADL (Activities of Daily Living) self-care deficit. Needs assistance with .Moderate - Extensive assistance .Call light within reach and answer promptly . 2. On March 8, 2020, at 11 a.m., at the hallway near room [ROOM NUMBER], a resident was heard crying for help (Ayudame!) and knocking on a hard object. On March 8, 2020, at 11:02 a.m., Resident 55 was observed in bed requesting for help. The call light was observed not within her reach. A concurrent interview and observation was conducted with Certified Nursing Assistant (CNA) 3. She verified that the call light was on the side of the bed, and not within the resident's reach. CNA 3 further stated the call light should be within the resident's reach at all times. Resident 55's record was reviewed. Resident 55 was admitted on [DATE], with [DIAGNOSES REDACTED]. Resident 55's document titled, Care Plan, dated December 31, 2019was reviewed. the care plan, indicated, .Focus: at risk for fall .Intervention .Call Light within reach and answered promptly . The policy and procedure titled, Answering the Call Light, dated October 2010, was reviewed. The policy and procedure indicated, The purpose of this procedure is to respond to the resident's requests and needs .When the resident is in bed .be sure the call light is within easy reach of the resident .
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a copy of the Advance Directive (AD-written statement of a person's wishes regarding medical treatment) was in the resident's record for one of ten residents reviewed for AD (Resident 157). This failure had the potential for Resident 157's AD not be readily retrievable by the staff and by the physician, which could result in the resident's wishes for treatment not to be followed while at the facility. Findings: On March 9, 2020, at 9:19 a.m., Resident 157 's record was reviewed. Resident 157 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A concurrent interview and record review was conducted with Registered Nurse Supervisor (RNS) 2, she verified that Resident 157's advance directive was not present in the resident's record. Resident 157's History and Physical, dated February 22, 2020, indicated, .does not have the capacity to understand and make decisions . The policy and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) procedure titled, Advance Directives, dated December 2016, was reviewed. The policy and procedure indicated, .the Social Service Director or designee will inquire .about the existence of any advance directive .an advance directive shall be .in the medical record .
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete the Preadmission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) for two of two residents reviewed (Residents 7 and 58), when: 1. For Resident 7, the Level 1 evaluation was not completed when the resident exceeded 30 days in the facility; 2. For Resident 58, the [DIAGNOSES REDACTED]. These failures had the potential for Residents 7 and 58 not to receive the services they required in an appropriate setting as determined by the State Designated Authority. Findings: 1. Resident 7's record was reviewed. Resident 7 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 7's PASARR which was completed on April 29, 2019, indicated the resident will stay less than 30 days. On March 11, 2020, at 10:05 a.m., a concurrent interview and record review was conducted with Registered Nurse Supervisor (RNS) 1, she verified Resident 7's PASARR should have been updated when the resident stayed more than 30 days in the facility. A review of the facility policy and procedure titled, Preadmission Screening and Resident Review (PASSR), dated January 2014, indicated, .If the stay exceeds 30 days, the PAS/PASARR Level 1 evaluation must be completed by the 31st day . 2. Resident 58's record was reviewed. Resident 58 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician orders dated December 5, 2019, indicated the following: a. [MEDICATION NAME] Hcl Tablet ([MEDICAL CONDITION] medication capable of affecting the mind, emotions, and behavior) Give 100 mg (milligram) by mouth two times a day for [MEDICAL CONDITION] .; and b. [MEDICATION NAME] Hcl Tablet (a [MEDICAL CONDITION] medication) Give 50 mg by mouth at bedtime for Depression . The PASARR dated December 6, 2019, indicated, Resident 58 did not have a diagnosed mental disorder such as Depression and Resident 58 was not on prescribed psychotropic medications. On March 10, 2020, at 3:16 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated she was responsible for doing the PASARR. She stated the PASARR was miscoded. The DON stated the PASARR did not reflect Resident 58's [DIAGNOSES REDACTED]. The DON stated the PASARR should have indicated the resident's [DIAGNOSES REDACTED]. The policy and procedure titled, PREADMISSION SCREENING AND RESIDENT REVIEW (PASARR), dated January 2014,was reviewed. The policy and procedure indicated, .The Preadmission Screeening/Preadmission Screening and Annual Resident Review (PAS/PASARR) shall be completed for all residents initially admitted to this facility to determine if the resident is Mentally Ill (MI) or Mentally Retarded (MR). For the residents found to be mentally ill or mentally retarded, this screeening is used to determine whether the nursing facility care is appropriate and whether the resident needs specialized services .Serious Mental illness (SMI) Level II Criteria: The resident must meet the following criteria to determine serious mental illness .[DIAGNOSES REDACTED].Mood and [MEDICAL CONDITION] .
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** Based on interview and record review, the facility failed to provide the resident and the resident's representative a written summary of the baseline care plan for one of 32 residents reviewed (Resident 139). This failure had the potential to result in the resident and the representative not to be aware of the facility's plan in managing the needed services and treatments. Findings: On March 8, 2020, at 11:49 p.m., Resident 139 was interviewed. Resident 139 stated he was not given any written copy of his baseline care plan. Resident 139's record was reviewed. There was no documented evidence indicating a baseline care plan was provided to the resident. On March 10, 2020, at 12:22 p.m., a concurrent interview and record review was conducted with Registered Nurse Supervisor (RNS) 2. She verified that there is no documented evidence the resident was given a copy of the baseline care plan. RNS 2 stated the interdisciplinary team (IDT) would provide a copy of the base line care plan to the resident or responsible party (RP) within 24-48 hours from the day of admission. On March 10, 2020 at 2:30 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). She verified that there was no documented evidence the resident nor the RP was provided a copy of the baseline care plan. The DON stated the responsible party should have been contacted and provided with a copy of the baseline care plan. A review of the facility undated policy and procedure titled, Baseline Care Plans, indicated, .The facility must provide the resident and their representative with a summary of the baseline care plan .
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the staff provided nail care for two of two residents reviewed for activities of daily living (ADLs) (Residents 47 and 60). This failure could result in resident's long fingernails to harbor more dirt and bacteria potentially contributing to the spread of infection. Findings: 1. On March 9, 2020, at 2:15 p m., Resident 47 was observed with long and dirty fingernails. Resident 47's fingernails were observed with black matter underneath. Resident 47's record was reviewed. Resident 47 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The care plan dated December 11, 2019, indicated, Resident had ADL self-care deficit .needs Extensive assistance to total assistance with ADLs .Assist & (and) cue resident with .grooming and personal hygiene . The Minimum Data Set (MDS - an assessment tool) dated December 11, 2019, indicated, Resident 47 needed total assistance with personal hygiene. On March 10, 2020, at 10 a.m., Certified Nursing Assistant (CNA) 5 was interviewed. CNA 5 stated when she was doing ADLs for the residents, she would check resident's fingernails if they were clean. On March 10, 2020, at 10:06 a.m., during observation of Resident 47 with CNA 5, CNA 5 acknowledged Resident 47's fingernails were long and dirty. In a concurrent interview with CNA 5, CNA 5 stated Resident 47's fingernails should have been cut and cleaned. On March 11, 2020, at 9:38 a.m., the Director of Nursing (DON) was interviewed. The DON stated trimming and cleaning of fingernails were part of the resident's care. The DON stated the CNAs should have been checking the nails of the resident. She stated the CNAs were allowed to trim and clean the nails of the residents. 2. On March 8, 2020, at 12:31 p.m., during observation and interview with Resident 60, the resident was observed with long fingernails. Resident 60 stated his fingernails were already long and needed to be trimmed. Resident 60 stated he did not want dirty fingernails. Resident 60's record was reviewed. Resident 60 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated December 20, 2019, indicated Resident 60 needed limited assistance with personal hygiene. On March 11, 2020, at 10:14 a.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated Resident 60 needed limited assistance with ADL's. CNA 1 acknowledged Resident 60's fingernails were long. On March 11, 2020, at 11:34 a.m., Resident 60 was interviewed. Resident 60 stated his fingernails were not trimmed and he was waiting for the CNA to cut his nails. Resident 60 stated he asked the CNA three times this week; however, none of the staff came back to trim my nails. On March 11, 2020, at 11:53 a.m., the Director of Staff Development (DSD) was interviewed. The DSD stated the CNA should ask if the resident preferred to have fingernails' trimmed. The DSD stated the CNAs should do the trimming of the nails when requested. The policy and procedure titled, Care of Fingernails/Toenails, dated October 2010, was reviewed. The policy and procedure indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection .Nail care includes daily cleaning and regular trimming .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary treatment and services for

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) three of 32 residents reviewed (Residents 45 and 60) when: 1. For Resident 45, a skin assessment was not completed for the resident's multiple skin discolorations (bruises). This failure had the potential to result in the delay in treatment of [REDACTED]. 2. For Resident 45, the eyepatch was not applied to the resident's left eye as per physician's orders [REDACTED]. 3. For Resident 60, the hospice nurse did not communicate with the facility staff the newly prescribed medication ([MEDICATION NAME] inhaler -for the treatment of [REDACTED]. This failure resulted in the delay in administration of medication for Resident 60. Findings: 1. On March 8, 2020, at 2:46 p.m., Resident 45 was observed with multiple blackish red discolorations on both forearms. On March 8, 2020, at 2:56 p.m., the family member (FM) of Resident 45 was interviewed. The FM stated Resident 45 was on blood thinners and had been having multiple skin discolorations. Resident 45's record was reviewed. Resident 45 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Weekly Summary, dated March 4, 2020, indicated Resident 45 had no skin issues. There was no documentation an assessment was completed for Resident 45's multiple bruises. Resident 45's care plan indicated the following: a. On June 6, 2019, Risk for bleeding/bruising due to used of anticoagulant (blood thinner) .Check body & (and) report to MD (medical doctor) any of the following S/S (sign/symptom) of bleeding .discoloration . ; and b. On January 24, 2020, At Risk and or potential for further unavoidable skin breakdown due to Fragile skin .Will prevent/minimize skin breakdown .C.N.A. (Certified Nursing Assistant) to report any skin abnormalities to the LN (licensed nurse)/RN (registered nurse) when showering/bathing resident . On March 10, 2020, at 8:40 a.m., CNA 6 was interviewed. CNA 6 stated she would check the resident's skin during showers and would document any skin issues in the skin inspection form. In addition, she would report all skin issues to the charge nurse. CNA 6 stated Resident 45 had multiple skin discolorations; however, she could not tell if the skin discolorations were new or old. CNA 6 stated Resident 45's skin discolorations should have been documented in the skin inspection form and should have been reported to the charge nurse. On March 10, 2020, at 8:51 a.m., the Director of Staff Development (DSD) was interviewed. The DSD stated the practice of the facility was for the CNAs to report any skin issue to the charge nurse. She stated any skin issue should be documented in the resident's record. On March 10, 2020, at 8:59 a.m., a concurrent interview and record review was conducted with the Treatment Nurse (TN). The TN stated she was not aware of Resident 45's multiple skin discolorations. She stated the nurses should report all skin issues so she could initiate an assessment and monitoring. The TN stated there was no assessment for Resident 45's skin discoloration. The TN stated Resident 45's skin discolorations should have been assessed to develop new interventions. On March 10, 2020, at 9:21 a.m., Licensed Vocational Nurse (LVN) 1 was interviewed. LVN 1 stated there was no report of new skin discolorations for Resident 45. LVN 1 stated new skin discolorations would be a change of condition and would need an assessment and monitoring for 72 hours. In a concurrent observation of Resident 45 with LVN 1, she stated Resident 45's skin discolorations were new. 2. On March 8, 2020, at 2:46 p.m., Resident 45's left eyelid and surrounding area was observed with redness. In a concurrent interview, Resident 45 stated he was told by his eye doctor that he had an eye infection. Resident 45's record was reviewed. Resident 45 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician order [REDACTED]. every day shift for s/p (status [REDACTED]. On March 10, 2020, at 8:59 a.m., the Treatment Nurse (TN) was interviewed. The TN stated she see the resident on a daily basis to put an eye patch on the resident's left eye. In a concurrent observation, the TN verified Resident 45 did not have an eyepatch. The TN stated Resident 45 should always have an eye patch. On March 10, 2020, at 9:21 a.m., Licensed Vocational Nurse (LVN) 1 was interviewed. LVN 1 stated Resident 45 had eye infection and should have an eye patch at all times to avoid an infection. 3. On March 8, 2020, at 11:57 a.m., Resident 60 was interviewed. Resident 60 stated he wanted to have his medication [MEDICATION NAME] but the facility did not give it to him. Resident 60 stated [MEDICATION NAME] worked for him and he had been asking for [MEDICATION NAME] for two months. Resident 60's record was reviewed. Resident 60 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 60 was under hospice care. The hospice document titled, Interdisciplinary Plan of Care Revision/ Physician Orders, dated March 4, 2020, indicated Resident 60 was prescribed a [MEDICATION NAME] inhaler. On March 11, 2020, at 10:23 a.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 2. She verified that there was a physician order [REDACTED]. On March 11, 2020, at 10:23 a.m., Licensed Vocational Nurse (LVN) 2 was interviewed. LVN 2 stated she knew about Resident 60's request for [MEDICATION NAME] inhaler. LVN 2 stated she told the hospice nurse last week about the resident's request for [MEDICATION NAME] inhaler. She stated physician orders [REDACTED]. On March 11, 2020, at 10:38 a.m., Registered Nurse Supervisor (RNS) 1 was interviewed. RNS 1 stated the hospice doctor ordered the medication [MEDICATION NAME]. In addition, she stated the physician order [REDACTED]. The facility document titled Agreement for Nursing Facility, Inpatient and Inpatient Respite Services, dated September 11, 2019, indicated, .Communication .The parties will communicate pertinent information with each other either verbally or in the Residential Hospice Patient's record at least weekly and/or each hospice patient visit to ensure that the needs of each Resident Hospice Patient are addressed and met 24 hours per day. Documentation of such communication shall be included in the Residential Hospice Patient's medical record .
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** Based on observation, interview, and record review, the facility failed to ensure a fall pad was provided in accordance with the physician order, for one of four residents reviewed for falls (Resident 45). This failure had the potential to result in injuries when a resident had a fall. Findings: On March 8, 2020, at 2:56 p.m., the family member (FM) of Resident 45 was interviewed, and stated Resident 45 had multiple falls. The FM stated Resident 45 had a floor mat when he was in another room; however, the floor mat was removed when the resident had a room transfer. The FM stated he needed a floor mat so when he falls he would not get hurt. The FM further stated Resident 45 would benefit from the floor mat. In a concurrent observation of Resident 45, Resident 45 was in bed with no floor mat on both sides of the bed. Resident 45's record was reviewed. Resident 45 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician order [REDACTED]. The care plan dated June 6, 2019, indicated, At risk for falls with injury R/T (related to): poor safety awareness, impaired cognition, HX (history) of falls .Will be free from fall related injuries .Interventions .Fall pad as ordered . On March 11, 2020, at 7:41 a.m., Resident 45 was observed in bed with no fall pad on both sides of the bed. On March 11, 2020, at 7:50 a.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 45 did not have a fall pad. In a concurrent review of Resident 45's record, LVN 1 stated there was a physician order [REDACTED]. The DON stated the interdisciplinary team would assess for the resident's need for a fall pad. She stated Resident 45 should have a fall pad.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment in accordance with the physician's order for one resident (Resident 78) reviewed for oxygen treatment. This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and decline in the resident's health condition. Findings: On March 8, 2020, at 9:46 a.m., Resident 78 was observed in bed, in his room. An oxygen concentrator (a machine that supplies oxygen) was at Resident 78's bedside, and was not in use. On March 9, 2020, at 10:05 a.m., Resident 78 was observed again in his room, in bed, without oxygen in use. Resident 78's record was reviewed. Resident 78 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The physician's order dated October 8, 2019, indicated, Oxygen at 2-4 L/min (liters per minute) via nasal cannula (a tube used to deliver oxygen through the nose) continuous . On March 9, 2020, at 10:06 a.m., Licensed Vocational Nurse (LVN) 4 was interviewed, and she confirmed a physician's order for Resident 78 to receive oxygen continuously. LVN 4 stated Resident 78 should have been on oxygen. LVN 4 stated the physician's order was not followed. The facility policy and procedure titled, Oxygen Therapy, revised October, 2010, was reviewed. The policy indicated, .Verify that there is a physician's order .Review the physician's order or facility protocol for oxygen administration .
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the [MEDICAL TREATMENT] was assessed for bruit (rumbling or swooshing sound heard with a stethoscope) and thrill (vibration felt through palpation) before [MEDICAL TREATMENT] treatment for one of two residents reviewed for [MEDICAL TREATMENT] (Resident 123).This facility failure

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F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) increased the potential for the delayed detection, reporting, and/or management of complications from the [MEDICAL TREATMENT] for Resident 123. Findings: On March 8, 2020, at 3:39 p.m., Resident 123 was interviewed. He stated the [MEDICAL TREATMENT] access was not assessed by the facility staff before he leaves for [MEDICAL TREATMENT]. Resident 123's record was reviewed. Resident 123 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 123's History and Physical, dated January 29, 2020, indicated the resident has the capacity to understand and make decisions. Resident 123's document titled, Order Summary Report, dated January 29, 2020, indicated, [MEDICAL TREATMENT] 3x a week . On March 10, 2020, at 8:40 a.m, a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 3. She stated Resident 123's [MEDICAL TREATMENT] Communication Record, dated February 17, 2020, and March 3, 2020, did not indicate an assessment for bruit and thrill was completed. She stated the [MEDICAL TREATMENT] accesss site needs to be checked, to ensure patency. A review of the facility undated policy and procedure titled, [MEDICAL TREATMENT] DOCUMENTATION, indicated, .the facility shall maintain an ongoing communication with the [MEDICAL TREATMENT] center staff .Care Plan .reflect the [MEDICAL CONDITION] problems, complications .treatment plans .address the assessment .
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to arrange a referral to an outside opthalmology for one of 32 residents (Resident 123). This failure had the potential to negatively affect Resident 123's highest physical, mental and psychosocial well-being. Findings: On March 9, 2020, at 2:41 p.m., Resident 123 was interviewed. Resident 123 stated he started having poor eyesight last November 2019. Resident 123 stated he had appointment for an eye surgery but was cancelled. He stated staff from the facility promised to help with the appointment to the eye doctor but it did not happen. Resident 123's record was reviewed. Resident 123 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 123's History and Physical, dated January 29, 2020, indicated the resident has the capacity to understand and make decisions. On March 9, 2020, at 2:30 p.m. a concurrent interview and record review was conducted with the Social Services Director (SSD). The SSD verified the resident was seen in the facility by the opthalmologist on February 6, 2020, and was referred to an outside opthalmologist for a cataract surgery. There was no documentated evidence indicating a referral to an outside opthalmologist for a cataract surgery was arranged for Resident 123. A review of the facility policy and procedure titled, Social Services, dated October 2010, indicated, Medically- related social services is provided to maintain his /her highest practicable physical, mental, or psychosocial well-being .The social services is responsible .compiling and maintaining up-to-date information about community health and service agencies for resident referrals
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow up on the pharmacy recommendation for one of five residents reviewed for unnecessary medications (Resident 80). This failure had the potential to result in duplicate therapy and unnecessary use of medications. Findings: Resident 80's record was reviewed. Resident 80 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Order Summary Report, for the month of March 2020, indicated the following: a. Geri-[MEDICATION NAME] Syrup ([MEDICATION NAME]) Give 10 ml (milliliter) by mouth at bedtime for Cough.; and b. [MEDICATION NAME] Allergy Tablet ([MEDICATION NAME] HCl) Give 1 dose by mouth two times a day related to [MEDICAL CONDITION] ([MEDICAL CONDITION]- lung disease) . The document titled, MEDICATION REGIMEN REVIEW, dated September 2, 2019, indicated, .The following medications may be considered to be duplicative therapy when used together. Please have the physician document in their progress notes the reason both medications are needed: Geri-[MEDICATION NAME] and [MEDICATION NAME]? Why both? Suggest D/cing (discontinuing) one of these. There was no documentation indicating the pharmacy recommendation was followed up with the physician. On March 11, 2020, at 9:38 a.m., during a concurrent interview and review of Resident 80's record with the Director of Nursing (DON), the DON stated Resident 80 was still on [MEDICATION NAME] and [MEDICATION NAME]. She stated once the pharmacist gave the recommendation, the nurses would follow up with the physician. The DON stated if the physician did not agree with the pharmacy recommendation, there should be a documentation regarding the reason. The DON stated there was no documentation indicating the pharmacy recommendation was followed up for Resident 80. The DON stated the pharmacy recommendation should have been followed up with the physician and should have been documented in Resident 80's record.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from a medication error of 5 percent or greater. There were four (4) medication errors observed, a total of 30 opportunities, during the administration process for one of five residents (Resident 81). This failure resulted in a medication error rate of 13.33 %. Findings: On March 10, 2020, at 9:30 a.m., an observation of the medication pass was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 was observed preparing Resident 81's medications which included: one tablet of Aspirin (used to prevent blood clots), 1/2 tablet of [MEDICATION NAME] (for depression), one tablet of Multivitamin (supplement), and one tablet of Vitamin D3 5000 units (supplement). LVN 3 crushed the medications individually, mixed each medication with an apple sauce, and administered the medication to the resident by mouth. Resident 81's record was reviewed. Resident 81 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On March 10, 2020, at 10:20 a.m., a concurrent interview and record review was conducted with LVN 3. LVN 3 stated the resident wanted his medications crushed; however, there was no physician order to crush Resident 81's medications and mix the medications with apple sauce. On March 10, 2020, at 3:31 p.m., the Director of Nursing (DON) was interviewed. The DON stated there should be a physician order to administer the medications crushed and mixed with an apple sauce. The facility's policy and procedures titled, Administering Medications, revised December 2012, was reviewed. The policy indicated, .Medications must be administered in accordance with the orders .
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1.Ensure discontinued IV (intravenous-administered through the vein) antibiotic medications were removed from the medication cart. This failure increased the risk for medication diversion. 2. Ensure medications were stored in the medication refrigerator under proper temperature. This failure had the potential to affect the efficacy of the medications. Findings: 1. On March 9, 2020, at 3:26 p.m., an IV Cart inspection was conducted with Registered Nurse Supervisor (RNS) 1. The IV cart contained three bottles of Cetazidime (antibiotic) IV medication with normal saline solutions. In a concurrent interview with RNS 1, RNS 1 stated the IV medications were already discontinued. She stated the medications should have been taken out from the cart and disposed as soon as possible. On March 11, 2019, 9:32 a.m., the Director of Nursing (DON) was interviewed. The DON stated discontinued medications should not be in the medication cart. The DON stated discontinued medications should be stored in the medication room for disposal. 2. On March 9, 2020, at 3:59 p.m., an inspection of the South Medication Room was conducted with Registered Nurse Supervisor (RNS) 3. During inspection, the refrigerator temperature was observed at 26 degrees Fahrenheit. The following medications were observed inside the medication refrigerator: a. Two vials of [MEDICATION NAME] (medications for high blood sugar) 100 unit/ml (milliliter); b. Three flextouch insulin pens (pre-filled pen used to deliver consistent insulin doses); c. Two vials of [MEDICATION NAME] (medications for high blood sugar) 100 unit/ml; d. One Basaglar ([MEDICATION NAME]-medication for high blood sugar) quickpen; e. Two vials of [MEDICATION NAME] (medication to treat low red blood cells) 20,000 units/ml; f. Nine vials of [MEDICATION NAME] (test used to detect [MEDICAL CONDITION] infection); g. One 30 ml bottle of [MEDICATION NAME] (antianxiety and [MEDICAL CONDITION] medication); h. Two opened

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555566	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONA POST ACUTE CENTER	**2600 SOUTH MAIN STREET CORONA, CA 92882**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) bottles of [MEDICATION NAME] (used to treat nerve pain) solution; and i. One vial of influenza vaccine. In a concurrent interview with RNS 3, RNS 3 stated the referigerator temperature was low. RNS 3 stated the refrigerator temperature should be between 36 to 45 degrees Fahrenheit. According to Lexicomp (a nationally recognized drug reference), the above medications should be stored at 2C to 8C (36F to 46F).
F 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete the physician order [REDACTED]. Findings: Resident 56's record was reviewed. Resident 56 was admitted on [DATE], with [DIAGNOSES REDACTED]. The physician order [REDACTED]. The order indicated, .UA with C&S in the AM (morning) . On March 10, 2020 at 11:26 a.m., a concurrent interview and record review was conducted with Registered Nurse Supervisor (RNS) 1. RNS 1 stated she called the laboratory and verified that there was no urine specimen collected for Resident 56. RNS 1 stated the licensed nurses should have checked if the urine specimen was collected and should have followed up with the results. On March 14, 2019, at 10:17 a.m., the Director of Nursing (DON) was interviewed. The DON stated the licensed nurse upon collection of specimen, should have called the laboratory and made sure the specimen was picked up. The facility policy and procedures titled, "Record Content .Laboratory and Radiology Reports, dated January 2014, was reviewed. The policy indicated, .The licensed nurse .will be responsible for faxing each report to the attending physician promptly after nurse's review .Contact the service and request an immediate copy of the laboratory or radiology reports that are not received within 48 hours .
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a written Notice of Medicare Non-Coverage (NOMNC- used to inform the beneficiary of his/her right to an expedited review of termination of services) was accurately completed for one of 32 residents reviewed (Resident 10). This failure had the potential for the facility not to be certain of when the beneficiary protection notice was signed. Findings: On March 9, 2020, at 3:44 p.m., Resident 10's record was reviewed. Resident 10 was admitted to the facility September 13, 2019, with [DIAGNOSES REDACTED]. On March 9, 2020, at 3:59 p.m., during a concurrent interview and record review with the Business Office Manager (BOM), she verified Resident 10's NOMNC did not indicate the date of when the document was signed. The BOM stated the date should be before the end of the service to provide Resident 10 enough time to appeal.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to practice the proper infection control precaution, when one facility staff failed to perform hand hygiene in between assisting two residents (Residents 54 and 156) during meals. This failure had the potential to result in transmission of infection to the residents. Findings: On March 8, 2020, at 1:11 p.m., during lunch meal observation, Restorative Nursing Assistant (RNA) 1 was observed feeding Resident 54. RNA 1 after assisting Resident 54, turned and began feeding Resident 156 without performing hand hygiene. On March 8, 2020, at 1:30 p.m., RNA 1 was interviewed, and stated she did not perform hand hygiene in between feeding the residents. RNA 1 stated she should have washed her hands. On March 10, 2020, at 1 p.m., the Infection Control Nurse (ICN) was interviewed. The ICN stated staff should perform hand hygiene before and after feeding each resident. The facility policy and procedure titled, Handwashing/Hand Hygiene, dated August 2014, was reviewed. The policy and procedure indicated, .Use an alcohol-based hand rub containing at least 62% alcohol; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .before and after assisting a resident with meals .