STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055255	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corona Health Care Center	1400 Circle City Drive Corona, CA 92879

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40000 Based on interview and record review, for three of eight residents reviewed for Advance Directive (AD - written instruction related to the provision of health care when the resident is no longer able to make decisions), the facility failed to ensure: 1. For Resident 38 and 76, a copy of their formulated AD was available for review in the resident's medical records. This failure had the potential for Residents 38 and 76's treatment wishes to not be honored; and 2. For Resident 37, the POLST (Physician Orders for Life-Sustaining Treatment - a portable medical order form that records the resident's treatment wishes for emergency personnel reference) was completed by the resident's representative to indicate the resident's care treatment. This failure had the potential for the facility staff to be not aware of Resident 37's treatment wishes and unable to implement the plan of care for the resident's medical condition. Findings: 1a. On June 27, 2024, Resident 38's record was reviewed. Resident 38 was admitted on [DATE], with diagnoses which included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and malignant neoplasm of esophagus (cancer of the throat). A review of Resident 38's Minimum Data Set (MDS - an assessment tool), dated March 13, 2024, indicated a BIMS (Brief Interview of Mental Status) score of 12 (cognitively intact). Further review of Resident 38's record indicated there was no AD Acknowledgement Form completed by the resident to indicate if the resident had a formulated AD or wish to formulate an AD. On June 28, 2024, at 9:25 a.m., an interview was conducted with the Social Service Director(SSD). The SSD stated Resident 38 did not have an AD Acknowledgement Form but had a formulated AD which Resident 38's family/POA (Power of Attorney) had provided the facility in January 2024. The SSD stated she could not find the copy of the formulated AD in Resident 38's record. The SSD stated a copy of Resident 38's formulated AD should be in the resident's medical record to ensure the resident's treatment wishes should be the same as the signed POLST. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. On June 27, 2024, Resident 76's record was reviewed. Resident 76 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke) and sickle cell disease (a group of disorders that cause red blood cells to become misshapen and break down). A review of Resident 76's MDS, dated [DATE], indicated a BIMS score of 13 (cognitively intact). A review of Resident 76's undated Advance Directive Acknowledgement, indicated the resident formulated an AD. Further review of Resident 76's record did not indicate a copy of the resident's formulated AD was available in Resident 76's record for review. On June 27, 2024, at 4:25 p.m., a concurrent interview and record review was conducted with the SSD. She stated Resident 76's formulated AD was not available in the resident's medical record. She stated Resident 76's formulated AD should be in the resident's medical record easily accessible for review. A review of the facility's policy and procedure titled, Advance Directive, dated September 2022, indicated, . The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with the state law and facility policy .Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives . If the resident or the residents (sic) representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents (sic) medical record and are readily retrievable by any facility staff . 2. On June 27, 2024, Resident 37's record was reviewed. Resident 37 was admitted to the facility on [DATE], with diagnoses which included respiratory failure (lung failure with difficulty breathing). A review of Resident 37's MDS, dated [DATE], indicated Resident 37 had a BIMS score of 14 (cognitively intact). A review of Resident 37's POLST, indicated Resident 37's representative signed the POLST on June 22, 2024. Resident 37's signed POLST did not indicate the resident's treatment wishes the staff should follow in case of an emergency. On June 27, 2024, at 10:45 a.m., an concurrent interview and record review was conducted with the SSD. The SSD stated the Resident 37's POLST should have been completed by the resident representative to indicate what treatment wishes the resident wanted in case of an emergency. A review of the facility's undated policy titled, Physician Order for Life Sustaining Treatment (POLST), indicated, .The POLST form should be executed as part of the health care planning process .Completion of a POLST form should reflect a process of careful decision making by the resident, or if the resident lacks decision making capacity the resident's legally recognized health care decision maker .If a resident who has decision making capacity, or the legally recognized health care decision maker wishes to complete a POLST form during the resident's stay, they shouold discuss the POLST form with the physician and/or the resident then complete and sign .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49113 Based on interview and record review, the facility failed to ensure eligible residents were provided with a Skilled Nursing Facility (SNF) Advanced Beneficiary Notice of Non-Coverage (ABN- a notice a provider gives after receiving services based on Medicare, federal funded program that covers skilled nursing facility in writing), for two of three residents reviewed for beneficiary notice (Residents 75 and 52). This deficient practice had the potential for the residents not to be informed of services should they decide to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility. Findings: 1. On June 28, 2024, at 09:45 a.m., a concurrent interview and record review was conducted with the Business Office Manager (BOM). The BOM stated Resident 75 was readmitted from the general acute hospital (GACH) on February 28, 2024. The BOM stated Resident 75 was provided skilled services under Medicare Part A from February 28, 2024, to April 12, 2024. The BOM stated Resident 75 was transferred from skilled care to custodial care effective April 13, 2024, and stayed in the facility. The BOM stated Resident 75 was not provided SNF-ABN when the resident was discharged from skilled services on April 13, 2024. The BOM stated Resident 75 should have been provided a SNF-ABN when the resident started to receive custodial care on April 13, 2024. 2. On June 28, 2024, at 6:20 p.m., a concurrent interview and record review was conducted with the BOM. The BOM stated Resident 52's last covered day from skilled services was March 6, 2024 and Resident 52 transitioned to custodial care on March 7, 2024. The BOM stated there was no SNF-ABN provided to Resident 52 on March 6, 2024. The BOM stated Resident 52 should have had an SNF-ABN. On June 28, 2024, at 6:28 p.m., a concurrent interview and record review was conducted with the Social Services Director (SSD). The SSD stated there was no SNF-ABN provided to Residents 75 and 52. The SSD stated the SNF-ABN form should have been provided for both Residents 75 and Resident 52. A review of the facility's undated policy and procedure titled ABN Policy and Procedures, indicated, . Medicare requires SNF to issue the SNF-ABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47374 Based on interview and record review, the facility failed to accurately code the Minimum Data Set Assessment (MDS - a resident assessment instrument), for one of one resident reviewed for hospitalization (Resident 88). This failure had the potential to cause inaccuracy in identifying Resident 88's care and support needs, and cause delay in these needs being met. Findings: On June 27, 2024, at 10:10 a.m., during a concurrent interview and record review with the MDS Coordinator, she stated the Resident 88's Discharge MDS Section A - Identification Information, dated March 29, 2024, indicated the resident was entered as discharged to short term general hospital. She stated Resident 88 was discharged to home. The MDS coordinator stated Resident 88's MDS was not coded accurately. A review of CMS (Centers for Medicare and Medicaid Services) Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated October 2023, indicated, .this item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which individual was discharged helps to inform discharge planning .demographic and outcome information .

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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. 40000 Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the physician's order and the facility's policy and procedure, for two of two residents reviewed during medication storage inspection (Residents 192 and 51). This failure had the potential for Residents 192 and 51 to not receive the full efficacy of the medication and had the potential to place Residents 192 and 51 at risk to affect their health condition. Findings: 1. On June 27, 2024, at 10:50 a.m., Station 3 medication cart was inspected with Licensed Vocational Nurse (LVN) 2. The following bubble pack medications for Resident 192 were observed to contain medications/pills on the following bubble number (#): - Levothyroxin (medication to treat hypothyroidism [a condition in which the thyroid gland doesn't produce enough thyroid hormone which could disrupt heart rate, body temperature, and all aspects of metabolism.]) 75MCG (microgram - unit of measurement) take half tablet = 37.5 mcg once daily, give on an empty stomach; bubble # 26 and 27 contained one half pill each; - Metoprol Suc (medication to treat high blood pressure) 25MG (milligram - unit of measurement) ER (extended release), take three tabs = 75 mg once daily; bubble # 27 contained three tablets; - Diltiazem (medication to treat high blood pressure) 120 mg ER take one capsule once daily; bubble # 27 contained one capsule; - Eliquis (medication to prevent blood clots) 2.5 mg give one tablet twice a day; bubble # 27 contained one pill; and - Indapamide (medication to treat water retention and high blood pressure) 2.5 mg take one tablet once daily; bubble # 27 contained one pill. In a concurrent interview with LVN 2, he stated the bubble # indicated the date of the month. LVN 2 stated bubble # 26 and 27 indicated June 26 and 27, 2024. LVN 2 stated he was not able to administer to Resident 192 Levothyroxin on June 26 and 27, 2024, before breakfast as the resident was sleeping. LVN 2 stated he was not able to administer Resident 192's Metoprol, Diltiazem, Eliquis, and Indapamide in the morning (between 8 a.m. to 10 a.m.) as Resident 192 was sleeping and he got busy. Resident 192's Medication Administration Record (MAR), was concurrently reviewed with LVN 2. He stated he signed in Resident 192's MAR the above medications were administered on the time it was prescribed to be given (9 a.m.) even though he was not able to administer the medications. LVN 2 stated he should administered the medications to Resideetn 192 during the prescribed time and if he was not able to administer, he should have documented it in the MAR as not administered and indicate the reason why. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On June 27, 2024, at 10:50 a.m., Station 3 medication cart was inspected with LVN 2. The following bubble pack medications for Resident 51 were observed to contain medications/pills on the following bubble number (#): - Furosemide (medication to treat water retention) 20 mg one tablet once daily; bubble # 25, 26, and 27, contained one pill each bubble #; - Gabapentin (medication to treat muscle/nerve pain) 300 mg two capsule = 600 mg three times a day; bubble # 25, 26, and 27, contained two pills each bubble #; and - Spironolact (medication to treat water retention) 50 mg one tablet once daily; bubble # 25, 26, and 27, contained one pill each bubble #. In a concurrent interview with LVN 2, he stated Resident 51 was moved to Station 3 from another station on June 24, 2024. He stated he worked morning shift of June 25, 26, and 27, 2024, and could not find the morning medications of Resident 51 (furosemide, gabapentin, and sprironolact). He stated he tried ordering the medications from the pharmacy but was informed that it was not time for the medications to be refilled, so he did not have the medications of Resident 51 to be administered on June 25, and 26, 2024. He stated he was not able to administer Resident 51's morning (furosemide, gabapentin, and spironolact) and noon (gabapentin) medications on June 25, and 26, 2024, as they were not available. LVN 2 stated he found Resident 51's medication inside medication cart 1 on June 27, 2024, but was not able to administer the medications because resident did not want it earlier. On June 27, 2024, Resident 51's MAR, was reviewed. Resident 51's MAR indicated the following medications were signed as administered on June 25 and 26, 2024 , at 9 a.m.: - Furosemide 20 mg; - Sprironolactone 50 mg; - Tiotropium bromide 18 mcg; (medication to relax the muscles around the airways so that they open up and one can breathe more easily) - Gabapentin; - Arformeoterol tartrate 15 mcg/2ml (milliliter - unit of measurement) (medication to prevent and decrease wheezing and shortness of breath caused by breathing problems); and - Budesonide inhalation 0.5 mg/2 ml (medication used to prevent difficulty breathing, chest tightness, wheezing, and coughing caused by asthma). On June 27, 2024, at 11:55 a.m., during an interview with LVN 2, he stated Resident 51's tiotropium bromide, arformeoterol tartrate, and budesonide inhalation medications were not given on June 25 and 26, 2024, because he could not find the medications. LVN 2 stated he should have not signed the medications of Resident 51 as administered. He stated he should have administered resident's medications as ordered by the physician and according to the timeframe it was prescribed to be administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 27, 2024, at 1:18 p.m., during an interview with the Director of Nursing (DON), he stated medications should be administered to the residents according to the physician's order and according to the facility's policy on the timeframe the medication should be administered. The DON stated the Licensed Nurse (LN) should document in the resident's MAR as not administered and indicate the reason why it was not administered. A review of the facility's policy and procedure titled Documentation of Medication Administration, revised November 2022, indicated, .A medication administration record is used to document all medications administered .Documentation of medication administration includes .date and time of administration . reason(s) why a medication was withheld, not administered, or refused .

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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** 41459 Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided, for one of five residents reviewed for oxygen (Resident 77), when a humidifier bottle (a medical device used to increase moisture and decrease dryness from oxygen) was found undated. This failure had the potential to place Resident 77 at risk for infection and respiratory failure. Findings: On June 26, 2024, at 11:16 a.m., Resident 77 was observed sitting upright in her bed, the resident had an oxygen concentrator next to her bed with a tubing connected to the oxygen concentrator with the flow of oxygen at the rate of 2 liters per minute via nasal cannula (a device that give you additional oxygen). An undated humidifier bottle was connected to the oxygen concentrator. On June 26, 2024, at 11:20 a.m., an interview was conducted with the Infection Preventionist (IP). The IP stated the humidifier bottle was not dated on the oxygen concentrator for Resident 77. The IP further stated the humidifier bottle should be dated and replaced daily to prevent risk of further infection. On June 26, 2024, at 11:22 a.m., an interview was conducted with the Certified Nursing Assistant (CNA 1). CNA 1 stated the humidifier bottle on the oxygen concentrator was not dated On June 27, 2024, a review of Resident 77 record indicated Resident 77 was admitted to the facility on [DATE] with diagnoses which included sepsis (life threatening complication of an infection). Resident 77 had currently been diagnosed with Covid 19 (an infectious disease caused by the SARS-CoV-2 virus). A review of Resident 77's Order Summary Report, included a physician's order, dated May 22, 2024, which indicated, .Oxygen at 2-3L/min (liters/minute) via nasal cannula . A review of the policy and procedure titled, Oxygen Administration, dated October 2010, indicated, . equipment used during oxygen administration .humidifier bottle(humidifying jar) .be sure water is in the humidifying jar .recheck the water level in the humidifying jar .the following information should be recorded . date and time .

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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. 40000 Based on observation, interview, and record review, the facility failed to ensure controlled medications (narcotic medications - used to treat moderate to severe pain) were accounted for, for five of five residents reviewed (Residents 26, 32, 21, 6, and 39) when the narcotic medications were not documented on the Medication Administration Record (MAR) as administered to the residents. In addition, Resident 26 and 39's narcotic pain medication was not given as ordered by the physician. These failures had the potential to result in possible diversion of controlled medications. Findings: On June 28, 2024, at 11:43 a.m., during a concurrent inspection the narcotic box of medication cart 3, interview, and record review with Licensed Vocational Nurse (LVN) 3, the following were observed: 1. Resident 26's narcotic count sheet indicated Norco (narcotic pain medication) 10/325 mg (milligram - unit of measurement) one tablet for moderate pain (pain rate scale of 4 to 6) every four (4) hours as needed and two (2) tabs every four (4) hours as needed for severe pain (pain rate scale of 7 to 10). Resident 26's narcotic count sheet for Norco 10/325 mg indicated 1 tab was taken out from the narcotic box but was not documented as administered to Resident 26 on the following dates and times: - June 20, 2024, at 6 a.m. and 2 p.m.; - June 21, 2024, at 6 a.m.; - June 24, 2024, at 6 a.m.; - June 25, 2024, at 6 a.m.; and - June 27, 2024, at 6 a.m. Resident 26's MAR and narcotic count sheet indicated one tab of Norco was administered to the resident when the pain rate scale was 7 (severe pain) on the following dates and times: - June 21, 2024, at 2 p.m.; - June 25, 2024, at 2:35 p.m.; and - June 27, 2024, at 2 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 32's narcotic count sheet indicated Norco 5/325 mg one tablet every six (6) hours as needed for moderate to severe pain (pain rate scale of 4 to 10). The Norco narcotic count sheet for Resident 32 indicated the medication was taken out from the narcotic box on June 25, 2024, at 8:45 a.m., but was not documented in the MAR as administered to Resident 32. 3. Resident 21's narcotic count sheet indicated Norco 7.5/325 mg one tablet every four hours as needed for moderate to severe pain (pain rate scale of 4 to 10). The Norco narcotic count sheet for Resident 21 indicated the medication was taken out from the narcotic box on June 2, 2024, at 4:44 p.m., but was not documented in the MAR as administered to Resident 21. 4. Resident 6's narcotic count sheet indicated Norco 5/325 mg one tablet every four hours as need for pain. The Norco narcotic count sheet for Resident 6 indicated the medication was taken out of the narcotic box but was not documented in the MAR as administered to Resident 6 on the following dates and times: - May 1, 2024, at 11 a.m.; - May 5, 2024, at 10 p.m.; and - May 24, 2024, at 11 a.m. 5. Resident 39's narcotic count sheet for tramadol (narcotic pain medication) 50 mg one tablet every six (6) hours as needed for moderate pain 4 -6 and two tablets every six hours as needed for severe pain (7 - 10). The tramadol narcotic count sheet for Resident 39 indicated the medication was taken out of the narcotic box but was not documented in the MAR as administered to Resident 39 on the following dates and times: - June 10, 2024, at 9:43 a.m.; and - June 14, 2024, at 5:02 p.m. Resident 39's MAR and narcotic count sheet indicated one tab of tramadol was administered to the resident when the pain rate scale was 7 (severe pain) on the following dates and times: - June 6, 2024, at 5:32 p.m.; - June 7, 2024, at 9:07 p.m.; and - June 14, 2024, at 9:11 a.m. In a concurrent interview with LVN 3, she stated the LN should document in the narcotic count sheet of the medication being taken out and document in the resident's MAR as administered to the resident when the Licensed Nurse would take a narcotic medication out from the narcotic box. LVN 3 stated the dose to be given should match the pain rate scale according to the physician's order. She stated this was not done by the licensed nurse for Residents 26, 32, 21, 6, and 39. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 28, 2024, at 2:21 p.m., during an interview with the Director of Nursing (DON), he stated the LN should document in the narcotic count sheet of the medication being taken out and document in the resident's MAR as administered to the resident when the Licensed Nurse would take a narcotic medication out from the narcotic box. The DON stated the LN should administer the narcotic pain medication as indicated in the phsyician's order in reference to the pain rate scale. A review of the facility's policy and procedure titled Administering Pain Medications, dated October 2022, indicated, .Conduct a pain assessment as indicated .Administer pain medications as ordered .Document the following in the resident's medical record .Results of the pain assessment .Medication .Dose .Route of administration . A review of the facility's policy and procedure titled Documentation of Medication Administration, dated November 2022, indicated, .A medication administration record is used to document all medications administered .Documentation of medication administration includes .name and strength of the drug .dosage . date and time of administration .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to ensure psychotropic medications (medication to manage mental and mood disorders) were necessary in managing mental illness, for one of five residents reviewed for unnecessary medications (Resident 55), when there was no evaluation or assessment by the IDT (Interdisciplinary team - a group of healthcare professionals) and psychiatrist prior to the use of risperidone (medication to treat mental illness). This failure had the potential for Resident 55 to receive unnecessary psychotropic medication and placed the resident at risk for adverse reactions. Findings: On June 27, 2024, Resident 55's record was reviewed. Resident 55 was readmitted to the facility on [DATE], and initial admitted [DATE], with diagnoses which included depression (feeling of sadness) and schizophrenia (a mental illness). A review of Resident 55's physician orders, dated November 19, 2023, included an order for risperidone 1 (one) mg (milligram - unit of measurement) two times a day for schizophrenia m/b (manifested by) delusion of persecution (belief that harm is going to occur to oneself by a persecutor, despite a clear lack of evidence). A review of Resident 55's Progress Notes, documented by the psychiatrist, dated December 11, 2023, at 11:43 a.m., indicated, .GDR (Gradual Dose Reduction) trial - Decrease Risperidone 0.5mg PO (oral) BID (two times a day) x(times) 4 (four) weeks then D/C (discontinue) - schizophrenia/hallucinations (a false perception of objects or events involving your senses) . A review of Resident 55's physician order, dated December 20, 2023, included an order for risperidone 0.5 mg two times a day for schizophrenia m/b delusion of persecution until 01/17/2024 (January 17, 2024). A review of Resident 55's Medication Administration Record, for the month of January 2024, indicated risperidone 0.5 mg. BID was discontinued on January 8, 2024. A review of Resident 55's Behavior Monitoring, indicated there was no episode of delusion of persecution for the months of December 2023, January and February 2024. A review of Resident 55's Progress Notes, dated February 23, 2024, at 9:48 a.m., indicated Resident 55 was transferred to the general acute hospital (GACH) due to abnormal lab (laboratory) result. A review of Resident 55's transfer orders to GACH indicated there was no order for risperidone upon discharge to the hospital. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 55's physician order, dated March 19, 2024, indicated and admission order for risperidone 1 mg twice a day for schizophrenia m/b auditory and visual hallucinations (a false perception of objects or events involving sense of hearing and sight). Further review of Resident 55's record indicated there was no documented evidence Resident 55 was assessed/evaluated by the prior to initiating or resuming risperidone 1 mg after it was discontinued on January 8, 2024. In addition, there was no documented evidence the psychiatrist evaluated Resident 55 prior to the use of risperidone. On June 28, 2024, at 11 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 55's risperidone was decreased from 1 mg to 0.5 mg BID on December 20, 2023, after the psychiatrist recommended for GDR on December 11, 2023, then eventually discontinued after four weeks. The DON stated there was no order for risperidone when Resident 55 was discharged to the GACH on February 23, 2024. The DON stated Resident 55 did not have behavior of delusions and/or hallucinations after risperdione was discontinued on January 8, 2024. The DON stated the facility reordered risperidone 1 mg BID when Resident 55 was readmitted on [DATE]. The DON stated there was no documentation Resident 55 was assessed by the IDT or the psychiatrist prior to the use of risperidone. The DON stated Resident 55 should have been assessed or evaluated prior to the use of risperidone. A review of the facility's policy and procedure titled Psychotropic Medication Use, dated July 2022, indicated, .Residents will not receive medications that are not clinically indicated to treat a specific condition .A psychotropic medication is any mediation (sic) that affects brain activity associated with mental processes and behavior .When determining whether to initiate, modify, or discontinue medication therapy, the IDT conducts an evaluation of the resident. The evaluation will attempt to clarify whether .signs and symptoms are clinically significant enough to warrant medication therapy .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459 Based on observation, interview, and record review the facility failed to ensure medications were stored and labeled according to the facility's policy and procedure when: 1. Multiple over the counter and treatment medications were not identifiable to be discarded or disposed of, were readily available for use in medication storage room at Station 1; 2. Three (3) Luer Lock (brand of syringe) IV (intravenous - through the vein) kits were found expired in the IV Cart; 3. Two (2) bags of 250 ml (milliliter - unit of measurement) normal saline IV were unlabeled and readily available for use in the IV cart; 4. For Residents 68 and 49, multiple medications of different forms and route were stored together in an area in the med cart of station three (3); 5. For Residents 85, 58, and 53, the discontinued meds were found stored in the med cart station three (3) readily available for use; and 6. For Resident 68, the label on the medication bottle found in the narcotic box containing 10 pills in station three (3) was not clear or legible. These failures have the potential for the residents to receive wrong, contaminated, expired, or ineffective medication therapy. Findings: 1. On [DATE], at 3:44 p.m., a concurrent observation and interview was conducted with the Infection Preventionist (IP) and Minimum Data Set (MDS) Coordinator during inspection of the medication storage room at nurse's station 1. The bottom two shelves of the medication storage room contained used and expired treatment creams and a box containing multiple over counter medications and supplements. The IP and MDS Coordinator stated the used and expired items should not be mixed with the supplements or medications that will be administered to the residents. On [DATE], at 3:47 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated all these items should have been placed for discard/disposal, the items should not have been placed back in the medication storage room. 2. On [DATE], at 10:30 a.m., a concurrent observation and interview were conducted with Registered Nurse (RN) 3. An observation of the IV cart was conducted and observed there were three (3) Micron Luer Lock IV kits found to be expired on [DATE]. RN 3 stated she would not use the IV kits as they were expired. She further stated the expired IV kits should not be ever used. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE], at 12:10 p.m. an interview was conducted with the DON. The DON stated the expired Luer Lock IV kits should not be in the IV cart. 3. On [DATE] at 10:45 a.m., a concurrent observation and interview were conducted with RN 3. An observation of the IV cart was conducted, two (2) bags of 250 milliliters (ml - unit of measurement) normal saline IV were found unlabeled ready for resident use. RN 3 stated another employee could use the IV bags, putting a resident at risk for contamination or infection. On [DATE] at 10:15 a.m. an interview was conducted with the DON. The DON stated the IV bags of 250 mls or more are required to be in an enclosed bag and have a label for identification. A review of the policy and procedure titled, Medication Storage, dated [DATE], indicated, . Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed . A review of the policy and procedure titled, Medication Labeling and Storage, dated February 2023 indicated if the facility has discontinued, outdated or deteriorated medications or biologicals, the pharmacy, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .medications for extrernal use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from other medications .if medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items . 40000 4. On [DATE], at 12:46 p.m., an inspection of station 3 medication cart was conducted with Licensed Vocational Nurse (LVN) 3. The following medications were observed stored together in an area on the top shelf of the medication cart for Residents 68 and 49: - hyoscyamine (medication to treat bladder or bowel cramps) tablets; - acetaminophen (medication to treat fever and pain) suppository (through the rectum); - ondansetron (medication to treat nausea and vomiting) tablets; - bisacodyl (medication to treat constipation) suppository; and - albuterol (medication to treat wheezing or shortness of breath) nebulizer (through a mist). In a concurrent interview with LVN 3, she stated the medications of different forms & routes should be stored separately to avoid mistake in administration of the medications. On [DATE], at 1:18 p.m., during an interview with the DON, he stated medications of different forms or route of admininistration should be stored separately (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled Medication Labeling and Storage, dated February 2023, indicated, .Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubible, drawerm or other holding area to prevent the possibility of mixing medications of several residents .Medications for external use, as well as hazardous drugs and biologicals, are cleacrly march as such, and are stored separately from other medications . 5. On [DATE], at 12:46 p.m., an inspection of station 3 medication cart was conducted with LVN 3. The following medications were discontinued and observed stored in the medication cart: - Three Lovenox (medication prevent blood clots) injectables labeled for Resident 85; - One bottle of ocean spray nasal spray labeled for Resident 53; and - One bottle of ciclopirox (medication to treat fungal infection) topical solution labeled for Resident 58. In a concurrent interview and record review with LVN 3, she stated Resident 3's Lovenox was discontinued on [DATE]. LVN 3 stated Resident 53's ocean spray nasal spray was discontinued on [DATE]. She stated Resident 58's ciclopirox was discontinued on [DATE]. LVN 3 stated the discontinued medications for Residents 95, 53, and 55 shoud be removed from the medication cart to prevent for the medications to be administered mistakenly. On [DATE], at 1:18 p.m., during an interview with the DON, he stated discontinued medications should not be in the medication cart. A review of the facility's policy and procedure titled Storage of Medications, dated [DATE], indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .Discontinued, outdated, deteriorated drugs or biologicals are returend to the dispending pharmacy or destroyed . 6. On [DATE], at 11:43 a.m., during an inspection with LVN 3, a bottle containing 10 pills labeled for Resident 68 was observed to have a medication label that was not legible to indicatte the name, dose, route of the medication, and the frequency of administration. LVN 4 and Treatment Nurse (TN) stated they are not able to identify the label of the medication on the bottle. LVN 4 stated Resident 68's medication label should be readable and legible. On [DATE], at 2:21 p.m., during an interview with the DON, a picture was shown of the medication bottle of Resident 68. The DON stated the label is not clear and readable. He stated the medication label should be clear and readable to prevent mistake in the medication administration. A review of the facility's policy and procedure titled Medication Labeling and Storage, dated February 2023, indicated, .If medication containers have missing, incomplete, improper or incorrect lables, contact the dispensing pharmacy for instructions regarding returning or destroying these items .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on interview and record review, the facility failed to ensure laboratory order for hemoglobin A1C (HgbA1C - blood test that shows what your average blood sugar (glucose) level was over the past two to three months) was completed as ordered, for one of five residents reviewed for unnecessary medications (Resident 53). This failure had the potential for Resident 53's blood sugar level to be uncontrolled and not be managed. Findings: On June 28, 2024, Resident 53's record was reviewed. Resident 53 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (DM - abnormal blood sugar). A review of Resident 53's physician order included the following medications to treat DM: - Humalog injection (insulin medication) per sliding scale (amount of units to be given according to the blood sugar level) before meals and at bedtime; and - Insulin Detemir solution (insulin medication) give 40 units twice a day. A review of Resident 53's physician order included the following laboratory orders: - A1C baseline lab on 1/14/24 (January 14, 2024); order date January 13, 2024; and - May have routine HgA1c (sic) lab work; order date April 17, 2024. Further review of Resident 53's record indicated there was no documented evidence the laboratory order for HgbA1C to be done on January 14 and April 17, 2024, was completed as ordered by the physician. On June 28, 2024, at 3:43 p.m., a concurrent interview and record review of Resident 53 was conducted with the Director of Nursing (DON). The DON stated he was unable to find results of the HgbA1C ordered to be done on January 14 and April 17, 2024. He stated he called the laboratory contracted by the facility, and was informed that there was no laboratory test for HgbA1C for Resident 53 completed on January 14 and April 17, 2024. The DON stated the HgbA1C ordered by the physician for Resident 53 should have been completed as ordered. A review of the facility's policy and procedure titled Laboratory and Diagnostic Test Results - Clinical Protocol, revised November 2018, indicated, .The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs .The staff will process test requisitions and arrange for tests .The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility .

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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. 47374 Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation and storage practices were followed in the kitchen when: 1. Food preparation and cooking pans (19 sheet pans, 3 baking pans, 1 steamer pan, 4 small deep container pans, 5 small shallow containers) were stacked wet one on top of another; 2. Dust was observed in several kitchen storage shelves, equipment, and ventilation vents; 3. Observed rust on the metal storage shelves, back stove hood, and fire suppression water pipes; 4. Wooden shelves in storage room were found with chipped paint and dust; 5. Dietary Aide (DA) 3 was observed not removing gloves and washing hands, after handling trash; 6. Observed broken and missing floor tiles in the walk-in-refrigerator, walk-in-freezer, back stove area, and dishwashing machine area; and 7. There was water pooling and unable to drain into the floor drain in the dishwasher area. These failures had the potential to cause food-borne illnesses in a highly susceptible resident population. Findings: On June 25, 2024, starting at 9:05 a.m., an initial tour of the kitchen was conducted with the Dietary Services Supervisor (DSS). The following were observed: - Grey and brown dust was observed in several storage shelves, equipment, and ventilation vents. During concurrent interview with the DSS, the DSS stated the shelves and vent covers had dust and dirt on them. Further stated cross contamination could happen with dust and dirt on the ventilation covers and shelves and could be harmful to residents; - Several wooden shelves attached to the back wall inside the dry storage room were found with chipped, peeling paint and dust. The DSS confirmed the painted shelves were chipped, peeling, and had brown dust and further stated there was potential for cross contamination with dust and chipped, peeling paint on shelves and could be harmful to residents; - Four (4) broken and three (3) missing floor tiles with brown deposits in the cracked tiles and uneven floor, where tiles were missing were observed inside the walk-in-refrigerator and the connected walk-in-freezer. The DSS confirmed broken and missing tiles and brown build up were present. The DSS further stated cross contamination could happen with missing or broken tiles and could be harmful to residents; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Food preparation and cooking pans (19 sheet pans, 3 baking pans, 1 steamer pan, 4 small deep container pans, 5 small shallow containers) were stacked one-on-top of another wet in the 3-sink washing area and clean storage. The DSS confirmed this was not appropriate stacking of wet cooking equipment and stated the potential for cross-contamination and spread of food-borne illness; - Red brown deposits were observed on the back stove inner, metal hood, and on the fire suppression water pipes on inside the stove hood, over the cooking surface during observation in the back oven area. The DSS stated the stove hood and fire suppression water pipes had areas of rust that could cause cross contamination with a potential to be harmful to residents; and - One broken and three missing floor tiles were observed and pooling water on the uneven floor not draining into floor drain at the dishwashing area. The DSS confirmed broken and missing tiles and waterpooling on the floor. The DSS further stated cross contamination could happen with the pooling water and broken tiles and could be harmful to vulnerable residents. On June 25, 2024, at 2:55 p.m., an interview was conducted with the Registered Dietician (RD). The RD stated weekly rounds and monthly sanitation rounds were to be done by the RD with the DSS. The RD confirmed the broken tiles and water lying on the floor in the dishwasher area. The RD further stated she was unaware of rusting in the back kitchen stove hood and fire suppressor pipes and outlets. The RD stated she had not observed the stacking of wet pans on-top-of-each-other or dirt and dust on the shelves. RD confirmed these failures have potential for cross-contamination and resident illness. On June 27, 2024, at 12:50 p.m., Dietary Aide (DA) 3 was observed removing trash from the kitchen to the outside container with gloves on. When returning to the kitchen DA3 did not discard his gloves or wash his hands after handling trash before going to the supply room. During a concurrent interview with DA3 and the DSS, the DA3 stated he should have removed gloves, washed hands, and put on a new pair of gloves prior to going into the supply room. DA 3 further stated it was important to prevent cross-contamination to food and could cause resident illness. A review of the facility's policy and procedure titled, Preventing Foodborne Illness - Food Handling, revised July 2014, indicated, .Food will be stored, prepared, handled and served so that risk of foodborne illness is minimized .All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness . A review of the facility policy and procedure titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices. revised October 2017, indicated, .Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness .Employees must wash their hands .after handling soiled equipment .whenever entering or re-entering the kitchen .after handling soiled equipment or utensils .after engaging in .activities that contaminate the hands . A review of the facility's policy and procedure titled, Sanitation, revised May 2023, indicated, .The Food & Nutrition Department .there shall be adequate equipment for cleaning and .general storage .all utensils, counters, shelves and equipment shall be kept clean .free from .cracks, and chipped areas .ceiling vents . hood over stove .cleaned by the maintenance staff .

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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** 49113 Based on observation, interview, and record review, the failed to ensure infection control measures were implemented according to the facility's policy and procedure, when: 1. The facility staff did not assess and change Resident 85's intravenous (IV- soft flexible tube placed inside a vein to give fluids or medicine) site when readmitted to the facility. This failure had the potential to cause a life threatening infection for the resident; and 2. The facility did not report in a timely manner to the California Department of Public Health (CDPH) when the facility had a COVID-19 (coronavirus - a contagious respiratory infection) outbreak on June 8, 2024. This failure had the potential to prevent effective outbreak management that could have potentially prevented further Covid cases. Findings: 1. On June 25, 2024, at 12:36 p.m., Resident 85 was observed with an IV dressing placed to the top of right hand, undated, and unlabeled with transparent dressing lifting. In a concurrent interview with Resident 85, she stated she could not remember when the IV was placed. Resident 85 stated the last antibiortic was given on June 24, 2024. On June 25, 2024, at 11:45 a.m., a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1 was conducted. LVN 1 observed and acknowledged the IV site for Resident 85 was not labeled and dated. LVN 1 stated the insertion date and administration of the medications were to be written in the monitor log at the nurse's station. On June 25, 2024, at 12:11 p.m., a concurrent observation and interview with Registered Nurse (RN) 1 was conducted. RN 1 stated Resident 85 finished antibiotic treatment on June 24, 2024. RN 1 stated Resident 85's IV dressing should have be changed every seven days or as needed and must be labeled and dated at the time of insertion. RN 1 stated the IV was placed on June 17, 2024, at the hospital. RN 1 stated Resident 85's IV should have been assessed and labeled when Resident 85 was readmitted to the facility on [DATE]. RN 1 stated it's for infection control. RN 1 stated she wasn't aware Resident 85 had an IV. RN 1 stated the facility's process for IV insertion was for the IV to be labeled with the date, time, and initialed when it was inserted. RN 1 was not able to state when the IV was last cleaned, changed, or dressed. On June 25, 2024, Resident 85's chart was reviewed. Resident 85 was readmitted on [DATE], with diagnoses which include atherosclerosis (a build up of fats and cholesterol plaque in the walls of the arteries), diabetes mellitus (a disease in which the body's ability to produce or respond to hormone insulin is impaired) and dysphagia (difficulty or discomfort swallowing. A review of Resident 85's Admission Summary, dated June 21, 2024, at 8:22 p.m. indicated Resident 85 was readmitted from the acute care hospital, with a peripheral IV site to the back of his right hand with intravenous antibiotics to be administered until June 24,2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 85 care plan, initiated on June 22, 2024, indicated, .The resident is on IV medication .IV DRESSING .Right back of hand. Observe dressing .change dressing, and record observation of the site . A review of the facility's policy and procedures titled Peripheral and Midline IV Dressing Changes, revised March 2022, indicated, .General Guidelines; perform site care and dressing change at established intervals or immediately of the integrity of the dressing is compromised. Maintain sterile dressing (transparent semi-permeable membrane [TSM] dressing or sterile gauze) for all peripheral catheter sites .Change the dressing .at least every 7 (seven) days for TSM dressing .and place new dressing (TSM or gauze) over insertion site. Label dressing with the date and time of dressing, and initials . 2. On June 27, 2024, at 4:26 p.m., an concurrent interview and record review was conducted with the IP. A review of the facility's Covid-19 Contact Line List and Covid-19 Rapid Test Log, indicated the first case of COVID 19 positive resident was on June 8, 2024. The IP stated COVID testing continued until June 27, 2024, with a total of 20 residents and 7 staff positive. The IP stated she did not report to California Department of Public Health (CDPH) because it was not an outbreak on June 8, 2024, as an outbreak was reportable unless there are three residents tested COVID positive. The IP stated the facility reported of the COVID outbreak on June 25, 2024 (at the start of survey) when the survey team was informed of the number of cases of COVID in the facility. The California Department of Public Health All Facilities Letter 2023-24 (AFL- a letter from the Center of Health Care Quality, Licensing and Certification Program to health facilities that are licensed or certified by Licensing and Certification), titled Healthcare-Associated Infections Program, was reviewed with the IP. The AFL indicated indicated, .Outbreak, Definitions, Reporting, and Duration of Outbreak Control Measures stated, Residents; greater than or equal to 1 facility-acquired Covid-19 case is to be reported . In a concurrent interview with the IP, based on the All Facilities Letter (AFL) 23-24, she should have reported to CDPH the facility's COVID outbreak when they had the first case of COVID positive on the residents. A review of the facility's policy and procedure titled Reporting Communicable Diseases, revised July 2014, indicated, .The purpose of this procedure is to guide reporting of suspected and confirmed communicable diseases to the appropriate governmental agency or authority .All reportable infectious diseases (residents' or employees') must be reported to the Infection Preventionist .The Infection Preventionist is responsible for notifying the local, district, or state health department of confirmed cases of state-specific reportable disease . A review of the facility's policy and procedure titled, Coronavirus Disease (COVID-19) - Documenting and Reporting COVID-19 Testing, dated September 2021, indicated, .Reporting .Notify the local health department promptly of the following .more than or equal to 1 (one) resident or staff member with suspected or confirmed SARS-CoV-2 infection .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055255	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corona Health Care Center	1400 Circle City Drive Corona, CA 92879

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47374 Based on observation, interview, and record review, the facility failed to follow their own policy and procedure to provide an environment free of pests, when black flies were observed flying and landing in the kitchen. This failure had the potential to lead to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) in the facility residents who eat food prepared in the kitchen. Findings: On June 25, 2024, at 10:16 a.m., a concurrent observation and interview was conducted with the the Dietary Services Supervisor (DSS) in the back stove area of the kitchen. One black fly was observed flying over the back stove area several times. The DSS confirmed the fly was present and it should not have been there, as could cause cross-contamination of the residents' food. On June 25, 2024, at 2:55 p.m., a concurrent interview and record review with the Registered Dietitian (RD). The RD confirmed this facility had a pest control issue with house flies. The RD stated her expectation was that the kitchen was not supposed to have any pests as they could spread disease through cross-contamination to residents. Further stated the facility had contract for regular pest control rounds. On June 26, 2024, at 9:15 a.m., an observation, interview and record review the Maintenance Supervisor (MS) stated his expectation was the kitchen was not supposed to have any pests. He stated the facility had a contract for regular pest control rounds and last visit was May 24, 2024 at 12:58 p.m. He further stated all doors and windows were closed and appropriately screened. On June 27, 2024, at 12:15 p.m., a concurrent observation and interview was conducted with the DSS and [NAME] 2 in the front stove and tray line area of kitchen. One black fly was observed flying over tray line, while food was being plated for residents' lunches. The DSS and [NAME] 2 confirmed fly was present over the tray line.The DSS further stated flies should not have been there, as could cause cross-contamination of the residents' food. A review of the facility's policy and procedure titled, Miscellaneous Areas, revised 2023, indicated, .FLY AND VERMIN CONTROL .Flies are carriers of disease and are a constant enemy of high standards of sanitation . All doors and windows must be properly screened .Food must be properly covered and store .arrangements . for pest control services on a routine basis .