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	07/24/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 written information to formulate an Advance Directive (AD - written instruction for the provision of care and services when unable to make decisions for oneself) was provided to the resident or the resident representative, according to the facility's policy and procedure, for two of two residents (Resident 49 and Resident 88). This failure had the potential for the residents to receive unnecessary care/treatment and services.Findings: 1. On July 21, 2025, at 10:18 a.m., Resident 49’s record was reviewed. Resident 49 was admitted to the facility on [DATE], with diagnoses which included Alzheimer’s dementia (memory loss). A review of Resident 49’s “Physician Orders for Life-Sustaining Treatment (POLST - a document that outlines a seriously ill or frail patient's preferences for medical treatment, particularly at the end of life), dated July 4, 2025, indicated Resident 49 had no AD, with the checkbox for legally assigned decision maker marked with a check. The form was signed by a resident representative (RR). A review of Resident 49’s “History and Physical Examination,” dated July 7, 2025, indicated Resident 49 did not have the capacity to understand and make decisions. A review of Resident 49’s “Minimum Data Set (MDS – a resident assessment tool), ” dated July 7, 2025, indicated Resident 49 had a BIMS (Brief Interview of Mental Status) score of 5 (severe cognitive impairment). There was no documented evidence formulation of an AD was offered to Resident 49 or Resident 49’s RR. On July 23, 2025, at 9:47 a.m., a concurrent interview and review of Resident 49’s record was conducted with the Medical Records Director (MRD). The MRD confirmed there was no documented evidence in Resident 49’s record that formulation of an AD was offered, and formulation of an AD should have been offered to Resident 49’s RR. The MDR further stated formulation of an AD should have been offered to the resident of resident representative upon admission and followed up within the first 14 days, during the period of baseline care planning. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On July 22, 2025, Resident 88’s record was reviewed. Resident 88 was admitted to the facility on [DATE], with diagnoses which included the right intertrochanteric femur fracture (broken upper thigh bone), status post cephalomedullary nailing (orthopedic implant for stabilization), and traumatic brain injury (injury to the brain). A review of Resident 88’s History and Physical Examination, completed by the physician on July 7, 2025, indicated Resident 88 had the capacity to understand and make decisions; A review of Resident 88’s SOCIAL SERVICES ASSESSMENT - INITIAL, dated July 7, 2025, indicated a check mark for POLST and a blank box for when and AD was offered. A review of Resident 88’s “POLST,” dated July 17, 2025, indicated a blank box for no AD, and the form was signed by Resident 88’s representative. On July 23, 2025, at 3:17 p.m., a concurrent interview and record review was conducted with the Case Manager (CM). The CM stated there was no documented evidence Resident 88 and/or Resident 88’s representative was offered education for AD or offered formulation of an AD. On July 23, 2025, at 3:39 p.m., a concurrent interview and record review was conducted with the MDS Coordinator (MDSC). The MDSC stated education for AD, and the formulation of an AD should have been offered to Resident 88 and/or Resident 88’s representative within 72 hours of admission. A review of the facility’s policy and procedure titled “Social Assessment,” revised July 2014, indicated, “…data obtained from social service assessment shall be used to develop…end-of-life care…wishes about medical treatment and care, including any advance directives…” A review of the facility’s policy and procedure titled, “Advance Directives,” dated December 2016, indicated, “…Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive is he or she chooses to do so…If the resident is incapacitated and unable to information about his or her right to formulate an advanced directive, the information may be provided to the residents legal representative…Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record…If the resident indicates that he or she has not established advanced directives, the facility staff will offer assistance in establishing advanced directives. Nursing staff will document in the medical record the offer to assist in the resident’s decision to accept or decline assistance…”

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility's policy and procedure on discharging a resident without a physician's approval was implemented, for one of three residents reviewed (Resident 102). This failure has the potential to place Resident 102 at risk for unsafe discharge.Findings:On July 24, 2025, Resident 102's record was reviewed. Resident 102 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus (abnormal blood sugar), hypertension (high blood pressure), muscle weakness, abnormality of gait and mobility, and local infection of the skin and subcutaneous tissue. A review of Resident 102's History and Physical, dated March 31, 2025, indicated Resident 102 had the capacity to understand and make decisions.A review of Resident 102's Progress Notes, indicated the following :-On May 21, 2025, at 11:16 p.m., completed by licensed nurse, .Resident went out on pass during the AM shift to move his belongings from apartment to storage with movers. Resident is alert oriented X (times) 4 (four), and self responsible .Charge nurse reported to writer that resident is not back from OOP (Out On Pass) .Charge nurse had called resident phone number several times, resident was not taking his calls .MD (medical doctor), DON (Director of Nursing), Administrator and SSD (Social Service Director) notified .resident sent text message to RN (Registered Nurse) phone stating;i (sic.) think I'm going to stay out here ihave (sic.) my medical supplies that were sent to the house i (sic.) have some in storage followed up with another phone call from the resident @11:02PM (p.m.), which he confirmed he is not coming back to the facility this night, writer told the resident that, not coming back to the facility this night will be considered Against Medical Advice (AMA). Resident stated,i (sic) will be coming back to the facility in the morning to take my belongings, confirming AMA verbally, MD made aware .-On May 21, 2025, at 11:51 p.m., completed by the SSD, . Resident contacted SSD via phone call .SSD asked Resident if would like to return to the facility. Resident did not respond. SSD advised resident he needs to return due to need of medications and insulin. Per resident stated I wish to not return back to the facility I feel that I no longer need medical attention of any sort and I d o not need medications .resident(sic.) asked for belongings to be packed and he would pick up in 5 days or send someone to pick up belongings in the next days. SSD advised resident if he does not return it will considered against medical advice. SSD advising him of risks and benefits. Resident continued to state he does not want to return to the facility, and he verbalized understanding regarding leaving against medical advice .-On May 23, 2025, at 1:23 p.m., completed by the SSD, .Resident came to the facility with friend . resident took all personal belonging with him. Resident thanked SSD for safeguarding personal belongings. SSD will continue to assist as needed .There was no documented evidence Resident 102 signed the AMA acknowledgement form indicating he was leaving against medical advice from the physician and the facility administration. In addition, there was no documented evidence from the licensed nurses notified the physician Resident 102 returned to the facility from OOP on May 21, 2025, and was being discharged as AMA on May 23, 2025. On July 24, 2025, at 2:30 p.m., Licensed Vocational Nurse (LVN) 5 was interviewed. LVN 5 stated the physician was to be notified if a resident wanted to be discharged AMA from the facility, and the resident to sign the AMA release form, with risks and benefits explained to the resident.On July 24, 2025, at 2:48 p.m., the Director of Nursing (DON) was interviewed. The DON stated the following procedure should be followed when a resident verbalized wishes to go AMA:- The physician should be notified;- The risks and benefits of being discharged AMA would be discussed with the resident; and- The resident should sign the AMA form and the licensed nurses were to notify the physician and to document in the progress notes the AMA resident discharge.The DON stated this process was not done on Resident 102's AMA discharge. The DON stated the licensed nurses were not informed by the SSD Resident 102 returned from OOP on May 23, 2025, and wished to be discharged AMA. The DON stated there was no documentation the SSD provided the AMA form to Resident 102 to sign upon AMA discharge, nor refused to sign the AMA form. The DON stated the facility's process on discharging a resident without a physician's approval was not followed. The DON stated the process should have been followed by the SSD and the licensed nurses.A review of the facility's policy and procedure titled, Discharging a Resident without a Physician's Approval, dated October 2012, indicated, .If the resident or representative (sponsor) insist upon being discharged without the approval of the attending physician, the resident and/or representative (sponsor) must sign a release of responsibility form. Should either party refuse to sign the release, such refusal must be documented in the resident's medical record and witnessed by two staff members.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure, for two of 20 residents reviewed (Residents 85 and 10):1. For Resident 85, had a follow-up appointment with neurology (study of the brain after hospital discharge) as ordered on the general acute hospital (GACH) discharge summary; and2. For Resident 10, the facility identified, monitored, and notified the physician in a timely manner, multiple skin discolorations on both hands and the left upper extremity.These failures had the potential for Residents 85 and 10 to have a delay in the care and treatment and placed the resident at high risk for complications. Findings: 1.On July 23, 2025, Resident 85’s record was reviewed. Resident 85’s “admission Record,” indicated Resident 85 was admitted to the facility on [DATE], with diagnoses which included seizures (abnormal electrical activity in the brain), narcolepsy (brain’s inability to regulate sleep-wake cycle). The “History and Physical,” completed by the physician, dated February 24, 2025, indicated Resident 85 did not have the capacity to understand and make decisions. The GACH Discharge summary, dated [DATE], indicated, “…follow-up…neurology within 5 (five) to 7 (seven) days…for titration (adjusting the dose of a medication) of antiepileptic (medication to treat epilepsy) regimen . The “IDT (Interdisciplinary Team – a group of healthcare professionals) Care Plan Conference Summary,” dated February 25, 2025, did not indicate Resident 85’s follow- up appointment with neurology was discussed; The physician telephone order, dated March 1, 2025, at 2:51 p.m., indicated, “…May have follow up with Neurology consult within 5-7 days r/t (related to) titration of antiepileptic regimen . The “Progress Notes,” dated March 1, 2025, at 2:58 p.m., indicated, “…writer got a call from (name of acute hospital)…who called to confirm if resident have been scheduled for neurology consult…resident is supposed to see neurology within 5-7 days following hospital discharge…order was placed for May follow up…SSD/CM (Social Service Director/Case Manager) please follow up with scheduling resident appointment…” The telephone physician order, dated March 20, 2025, indicated, “…discharge back to (name of Assisted Living) on March 20, 2025…” The “admission Record,” indicated Resident 85 was admitted back to the facility on April 24, 2025. The medical appointment with Neurology, dated June 26, 2025, indicated, “ .recently hospitalized …discharge summary…follow-up with neurology for adjustment of antiseizure medication…at risk for seizures…continue Keppra (brand name for antiseizure medication) 1000 mg (milligram-unit of measurement) twice a day…return in 6 months or sooner if needed…” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence that a follow-up appointment with neurology was arranged by the facility staff as ordered in the acute hospital Discharge summary dated [DATE]. In addition, there was no documented evidence that a follow-up appointment with neurology was arranged by the facility staff as ordered by physician on March 1, 2025, not until June 26, 2025 (four months after the recommendation by the acute hospital February 21, 2025). On July 23, 2025, at 11:05 a.m., a concurrent interview and record review was conducted with the DON (Director of Nursing). The DON stated Resident 85 was admitted to the facility on [DATE], and was discharged to an Assisted Living Facility (ALF) on March 20, 2025. The DON stated the hospital Discharge summary, dated [DATE], indicated follow up with neurology within 5 to 7 days. The DON stated the physician order, dated March 1, 2025, indicated follow up with neurology within 5 to 7 days. The DON stated Resident 85 did not see the neurologist prior to his discharge to the ALF on March 20, 2025. The DON stated Resident 85’s did not see the neurologist until June 26, 2025. The DON further stated Resident 85 should have seen the neurologist within 5 to 7 days as indicated in the hospital Discharge summary dated [DATE], and physician orders dated March 1, 2025. The DON stated the facility did not have a policy pertaining to scheduling resident appointments. 2. On July 21, 2025, at 4:23 p.m., Resident 10 was observed in bed, alert, and was able to be interviewed. Resident 10 was observed to have multiple purplish blue skin discolorations in various sizes on the hands. On July 23, 2025, Resident 10’s record was reviewed. Resident 10 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD – a progressive lung disease that makes it difficult to breathe), diabetes mellitus (abnormal blood sugar levels), and congestive heart failure (occurs when the heart doesn't pump enough blood to meet the body's needs). The “History and Physical,” dated June 6, 2025, indicated Resident 10 did not have the capacity to make decisions. The care plan, dated February 5, 2025, indicated, “…At risk for bleeding …At risk of alteration in skin integrity…Notify MD (medical doctor) of any bleeding episodes or any significant change in general condition, presence of bruises…” The facility document titled, “SHOWER SHEETS/BODY CHECK,” indicated the following: - On July 19, 2025, Resident 10 had “rashes” and “redness” on his forearms. The document did not indicate Resident 10 had multiple purplish blue skin discolorations on both hands; and - On July 23, 2025, Resident 10’s both forearms had “bruising, swelling,” and was “abnormal” in color. The document did not indicate the multiple purplish blue skin discolorations on both hands, which was identified since July 21, 2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence Resident 10’s multiple purplish blue skin discolorations on both hands, identified on July 21, 2025, were identified, addressed, and referred to the physician for treatment orders. On July 22, 2025, at 9:31 a.m., a record review was completed and noted that there was no documentation on the current skin discolorations within the care plan. On July 23, 2025, at 4 p.m., an observation was conducted on Resident 10. Resident 10 still observed to have the previously noted purplish blue discolorations on both hands and a pink skin discoloration on his left upper arm. On July 23, 2025, at 4:06 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 10 had a history of anticoagulant (blood thinner) use, combative behavior, and fragile skin, which made him a high risk for skin injury. LVN 1 stated Resident 10’s discolorations were “on and off.” LVN 1 stated new skin discolorations should be identified and monitored. LVN 1 stated she last saw Resident 10 on July 22, 2025, but did not notice purplish blue discolorations on both hands or redness on his left upper extremity. On July 23, 2025, at 4:20 p.m., an observation with a concurrent interview was conducted with LVN 1. LVN 1 measured the multiple skin discolorations on Resident 10’s both hands and left upper arm. The measurement were as follows: - “Left upper extremity ecchymosis (discoloration due to bleeding) that is red in color, 9 cm (unit of measurement) x 11 cm”; - “Left second digit with grayish purple discoloration, 6 cm x 3 cm”; and - “Right fourth knuckle with purple discoloration, 3.5 cm x 2 cm” In a concurrent interview, LVN 1 stated there was no care plan initiated regarding the multiple skin discolorations she just measured. LVN 1 stated for new skin issues, the licensed nurse should complete a change of condition report, incident report, and inform the resident’s physician and family. LVN 1 stated this process was not done for Resident 10 since the skin issues were identified on July 21, 2025. LVN 1 stated the lack of reporting and monitoring of identified new skin problems had the potential to delay in the care or identification of underlying issues. LVN 1 stated this can also cause skin problems to worsen, including bruising and pain. On July 24, 2025, at 3:15 p.m., the DON was interviewed. The DON stated any new skin discoloration should be investigated for cause and potential abuse. The DON stated a change of condition report and care plan should be completed. The DON stated licensed nurses should have reported, assessed, and notified the physician and family of Resident 10. The DON stated all these components should have been done at the point of discovery. The DON stated the staff did not identify the new skin discolorations on Resident 10, and this should have been reported as soon as possible. The DON stated the delay in identification could result in a delay in treatment. The DON stated staff should have identified it early so the appropriate interventions could be “instituted” and communicated to family, the physician, and the staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's document titled, Skin Tears - Abrasions and Minor Breaks, Care of, revised September 2013, indicated, .When an abrasion/skin tear/bruise is discovered, complete a Report of Incident/ Accident .Notify the responsible family member .Notify the physician of any abnormalities .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure, for one or three residents reviewed for accidents (Residents 24 and 57):1.Two person-assistance was provided during incontinent care (cleaning the resident while in bed after periods of urination or bowel elimination) in accordance with the plan of care, for Resident 24. This failure resulted to Resident 24 fell from the bed, complaint of pain and swelling at the right thigh, which indicated fracture (broken bone) to the right thigh, and subsequently was sent out to the acute care hospital for further management; 2. The smoking paraphernalia (cigarette and lighter) were stored in a secured container according to facility policy and procedure, for Resident 57. This failure has the potential to place Resident 57 at risk for smoking related accidents Findings:1.On July 21, 2025, at 3 p.m., Resident 24 was observed inside the room, awake and lying on an air loss mattress (designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) with raised sides to the bilateral head of the bed and foot of the bed. Resident 24 was not able to answer questions. On July 22, 2025, Resident 24's record was reviewed. A review of Resident 24's admission Record, indicated Resident 24 was admitted on [DATE], with diagnoses which included bilateral osteoarthritis (a chronic joint disease characterized by the breakdown of cartilage, the protective tissue that cushions the ends of bones in joint) of knee, right knee contracture (condition where a muscle, tendon, or joint becomes permanently shortened and stiff, limiting its range of motion), muscle weakness, and difficulty in walking.A review of Resident 24's Care Plan, dated June 21, 2024, indicated .resident has an ADL (Activities of Daily Living - fundamental self-care tasks essential for independent living, which include basic activities like bathing, dressing, eating, toileting, transferring) self-care performance deficit and needs substantial assist with mobility and ADLs. Interventions.Resident requires 2 person assist in toileting. A review of Resident 24's History and Physical, dated February 18, 2025, indicated Resident 24 did not have the capacity to understand and make decisions. A review of Resident 24's Fall Risk Assessment, dated April 15, 2025, indicated Resident 24 was high risk for falls.A review of Resident 24's Minimum Data Set (MDS - an assessment tool), dated April 16, 2025, indicated Resident 24 needed total assistance with rolling left and right and personal hygiene. Resident 24 was dependent for toileting hygiene and had functional impairments to bilateral upper and lower extremities (arms, hands, legs, and feet).A review of Resident 24's Progress Notes, indicated the following:-July 10, 2025, at 9:57 p.m., .According to the CNA (Certified Nursing Assistant), At 2120 (9:20 p.m.) resident was being changed.CNA.was trying to turn resident to the side away from her while grabbing on the chux (disposable, absorbent under pads designed to protect surfaces like mattresses and furniture from fluids), when resident flip from the order (sic) side of the bed away from the CNA.resident fell using the lateral side of her body to hit on the floor. The CNA was not sure if resident landed on the floor with left or right side of the body.Primary ambulance (first ambulance dispatched to an emergency call to initiate patient care and transportation) called.-July 11, 2025, at 8:46 a.m., .Resident returned back from hospital @ (at) 0800 (8 a.m.). no pain upon arrival to the facility.;-July 12, 2025, at 5:39 p.m., .Right lower extremity contracted (a condition where the tissues surrounding the joints and muscles in your right leg become stiff, tightened, or shortened, leading to restricted movement and potentially deformity) from hip and knee bent toward the left side.patient c/o (complaint of) right hip and knee pain.PCP (Primary Care Physician).gave order to have x-ray (a photographic or digital image of the internal composition of something, especially a part of the body).-July 13, 2025, at 10:41 a.m., .received abnormal X ray result and noted with Distal (refers to a part of the body that is farther away from the center of the body than another part) femur Fracture (a break in the femur, also known as the thighbone, which is the longest and strongest bone in the human body).new order to transfer patient to (name of hospital).-July 13, 2025, at 6:59 p.m., .Resident came back from the ER (Emergency Room.@ 1700 (5 p.m.).resident came back with right leg wrapped with bandage.A review of Resident 24's general acute hospital (GACH) records titled, ED Provider Note, dated July 13, 2025, indicated the following:- .Pt (patient) had fall approx. (approximately) 2 (two days ago.Facility noticed pt had right thigh area swelling and had CT (Computer Tomography - a medical imaging technique that uses X-rays to create detailed cross-sectional images of the body's internal structures, such as organs, bones, and blood vessels) done today. Pt found to have Distal femur fracture from CT scan today.;- .When asked, pt admits to some right knee pain.; - .XR (x-ray) Right Femur (thigh).There is a displaced fracture (a type of bone fracture where the broken bone fragments are no longer aligned with each other) of the distal femur ; and- . Per Orthopedics

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately conduct pain assessment, for one of one resident (Resident 24).This failure had the potential for Resident 24's pain to be unmanaged appropriately.Findings:On July 23, 2025 at 12:24 p.m., during a concurrent observation of Resident 24 and interview with Licensed Vocational Nurse (LVN) 6 in Resident 24's room, Resident 24 was assessed for pain in English and Spanish by LVN 6. Resident 24 did not verbally respond and did not gesture with any head nodding up and down or side to side. LVN 6 stated Resident 24 was in pain if she would grimace or moan.A review of Resident 24's admission Record, indicated Resident 24 was admitted on [DATE], with diagnoses which included bilateral osteoarthritis (a chronic joint disease characterized by the breakdown of cartilage, the protective tissue that cushions the ends of bones in joints) of knee, right knee contracture (a permanent shortening of muscles, tendons, or other tissues that restricts movement), and dementia (memory loss).A review of Resident 24's History and Physical, dated February 18, 2025, indicated Resident 24 did not have the capacity to understand and make decisions.A review of Resident 24's Minimum Data Set (MDS - an assessment tool), dated April 16, 2025, indicated a Brief Interview for Mental Status (BIMS) score of 00 (severe cognitive impairment).A review of Resident 24's Medication Administration Record (MAR), for the month of July 2025, included a physician's order, dated November 5, 2024, which indicated, Monitor Level of Pain Q (every) Shift (Scale 0-10): (0 = No Pain, 1-3 = Mild Pain, 4-5 = Moderate Pain, 6-9 = Severe Pain, 10 = Excruciating Pain). The MAR a pain scale of 4 on July 19, 2025.The July 2025 MAR also included pain medication hydrocodone administered to Resident 24 on July 14, and 16, 2025 with a pain scale of 7 and 8 respectively.On July 23, 2025 at 12:25 p.m., during a concurrent interview and record review with LVN 6, Resident 24's July 2025 Medication Administration Record (MAR), indicated a pain level of eight (8) on July 22, 2025 at 8 a.m. LVN 6 stated she assessed Resident 24's pain on this date and time and should have implemented the PAINAD (a tool used to assess pain in individuals with advanced dementia who cannot verbally express their pain) assessment scale because Resident 24 was not able to verbally rate her pain using the numeric pain scale. LVN 6 stated it was important to implement the appropriate pain scale to accurately assess how much pain the resident was experiencing.On July 24, 2025, at 8:52 a.m., during an interview with the Director of Nursing (DON), the DON stated the licensed nurse should have used the PAINAD scale to accurately assess Resident 24's pain since the resident was nonverbal at the time. The DON stated it was important to utilize the appropriate pain scale to ensure the assessment was accurate.A review of the facility's policy and procedures titled, Pain - Clinical Protocol, dated March 2018, indicated, . Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.

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Corona Health Care Center	1400 Circle City Drive Corona, CA 92879

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure, for one of one resident (Resident 7):- Post dialysis (a medical procedure that acts as an artificial kidney, used when a person's kidneys fail to remove waste and excess fluid from the blood) complications were appropriately monitored on July 21, 2025;- The physician was notified of Resident 7's low blood pressure after dialysis treatment; and- Resident 7 ‘s low blood pressure was not monitored. These failures had the potential to result in the untimely reporting of adverse effects and symptoms post dialysis, which could also result in a decline in health condition. Findings: On July 22, 2025, at 1:45 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN 2). LVN 2 stated a progress note were to be written when a resident would go out for dialysis treatment and another progress note to be documented when the resident would get back from the dialysis treatment. LVN 2 further stated upon a resident's return from dialysis treatment, the licensed nurse should conduct a complete physical assessment, check vital signs, weigh the resident, and assess the dialysis site. LVN 2 stated this assessment should be documented in the resident's medical record. LVN 2 stated Resident 7 went out for dialysis treatment on July 21, 2025, and there was no documentation of a complete assessment when the resident returned from the dialysis treatment.On July 22, 2025, Resident 7's record was reviewed. Resident 7 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (a chronic condition where the kidneys have permanently lost most of their function and can no longer effectively filter waste products from the blood) and dependence on renal dialysis.The care plan dated June 3, 2024, indicated, . Monitor VITAL SIGNS. Notify MD of significant abnormalities.Monitor/document/report PRN (as needed) for any s/sx (signs or symptoms) of renal insufficiency.The History and Physical Examination, dated February 20, 2025, indicated Resident 7 did not have the capacity to understand and make decisions.The physician's order, dated May 15, 2025, indicated, . Dialysis: Monitor for post dialysis treatment symptoms. Hypotension (low blood pressure), dizziness, nausea, vomiting, fatigue, fever, headache muscle weakness or cramps, itching, diarrhea or hypertension (high blood pressure), any symptoms Notify MD (medical doctor).There was no documented evidence Resident 7 was monitored for post dialysis treatment symptoms such as hypotension, dizziness, nausea, vomiting, fatigue, fever, headache, muscle weakness or cramps, itching, diarrhea and hypertension when she returned from the dialysis appointment on July 21, 2025.The Progress Notes, dated July 21, 2025, at 8 a.m., indicated, . was picked up at this time by (name of transport company) for dialysis this morning. There was no documented evidence that Resident 7 came back from dialysis.The document titled, HEMODIALYSIS COMMUNICATION RECORD, dated July 21, 2025, indicated Resident 7's vital signs prior to going for dialysis treatment. The lower portion of the document where vital signs and status of the resident post dialysis treatment should be documented was blank.The document titled, Blood Pressure Summary, indicated Resident 7 had the following blood pressure (BP):- On July 21, 2025, at 6:34 p.m., blood pressure was 104/50 mmHg (millimeters of mercury - unit of measurement); and- On July 21, 2025, at 6:34 p.m., warning was triggered for Diastolic (bottom number of blood pressure reading) Low of 60 exceededThere was no documented evidence Resident 7's post dialysis treatment BP reading of 104/50 was referred to the physician. In addition, there was no documented evidence Resident 7 was monitored and assessed for the low blood pressure reading after it was identified on July 21, 2025, at 6:34 p.m.On July 23, 2025, at 3:32 p.m. , a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the following regarding the facility's process when a resident would go out for dialysis treatment:- A binder would be sent with the resident which includes the pre/post dialysis communication record (Hemodialysis Communication Record) and the licensed nurse to complete the pre dialysis information;- The receiving licensed nurse must take vital signs and ensure the dialysis communication record was filled out by the dialysis center staff when the resident comes back from dialysis; and- The receiving licensed nurse should write a progress note and monitor the resident for post dialysis treatment symptoms.The DON stated Resident 7's Hemodialysis Communication Record, was not filled out by the receiving LVN and the LVN did not write a progress note on July 21, 2025, when Resident 7 came back from dialysis treatment. The DON stated Resident 7's blood pressure reading of 104/50, on July 21, 2025, at 6:34 p.m., was considered an abnormal value and it should have been reported to the physician. The DON stated there was no documentation that this was done. The DON further stated a low blood pressure reading that was not

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure provision of safe and effective pharmaceutical services to meet the needs of the residents when:1. For Resident 39, cholestyramine (medication used to lower cholesterol and treat itching or diarrhea caused by a buildup of bile acids [substances made by the liver that help digest fats]) was administered without appropriate separation from other oral medications, not in accordance with the manufacturer's instructions and the facility's consultant pharmacist's recommendation to separate administrations.This failure had the potential to result in reduced drug absorption, and inadequate medication treatment, compromising the effectiveness of other administered medications; and 2. The documentation on Controlled Drug Record (CDR, accountability records, an inventory sheet that keeps records of the usage of controlled medications) and Medication Administration Record (MAR) did not reconcile for two randomly selected residents (Residents 78 and 106). These failures resulted in inaccurate accountability of controlled substances (medication with high potential for abuse and addiction), which had the potential for misuse or diversion (medication taken by someone other than for whom it is prescribed) of controlled substances. Findings:1. On July 21, 2025, at 8:58 a.m., during a medication pass observation with Licensed Vocational Nurse (LVN) 3, LVN 3 was observed preparing a total of four oral medications for Resident 39. Included in the medications were 2 (two) tablets of acetaminophen (pain medication) 500 mg (milligram - unit of measurement), 1 (one) tablet of Eliquis (blood thinner) 5 mg, 1 (one) capsule of stool softener (docusate sodium, active ingredient) 100 mg, and UTI-Stat oral liquid (supplement) 30 ml (milliliter - unit of measurement). LVN 3 stated cholestyramine 4 gm (gram - unit of measurement) also needed to be administered but would first administer the four prepared medications and then obtain a graduated measuring cup from the supply room to dilute the cholestyramine powder in 8 oz (ounces - unit of liquid measurement) of liquid, as the cups available in the medication cart were too small to accurately measure the required 8 oz of liquid.On July 21, 2025, at 9:18 a.m., LVN 3 was observed administering the four prepared medications to Resident 39.On July 21, 2025, at 9:26 a.m., LVN 3 was observed preparing and administering the diluted cholestyramine to Resident 39.During a review of Resident 39's medical record, the following physician orders were noted:- Cholestyramine Light Packet 4 GM, Give 1 packet by mouth two times a day for Generalized body itching, Mix in 8 oz Liquid, dated December 1, 2024. The scheduled administration times were 8 a.m. and 5 p.m.;- Acetaminophen 500 MG, Give 2 tablets by mouth two times a day for Pain Management/chronic headache, dated July 24, 2024;- Apixaban (generic name for Eliquis) Oral Tablet 5 MG, Give 5 mg by mouth two times a day for PPX (prophylaxis, preventive) blood clots, Monitor for sign of bleeding/discolorations, dated June 21, 2025;- Stool Softener Oral Capsule 100 MG (Docusate Sodium), Give 1 capsule by mouth two times a day for constipation, hold for loose stool, dated December 25, 2024; and- UTI-Stat oral liquid (Cranberry-Vitamin C-Inulin), Give 30 ml by mouth one time a day for management, dated July 9, 2025.During a review of Resident 39's medical record, the MAR, dated June 2025 and July 2025, indicated the cholestyramine was administered at 8 a.m. and 5 p.m. through July 9, 2025, then at 10 a.m. and 6 p.m. beginning July 10, 2025. On July 21, 2025, at 3:08 p.m., during a concurrent interview and record review with LVN 3, LVN 3 reviewed the physician's order and stated the Director of Nursing (DON) had updated the administration time for cholestyramine from 8 a.m. and 5 p.m. to 10 a.m. and 6 p.m., as reflected in the revised physician's order dated July 9, 2025.On July 22, 2025, at 2:45 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON confirmed the administration times for cholestyramine had been updated from 8 a.m. and 5 p.m. to 10 a.m. and 6 p.m. on July 9, 2025, following the recommendation from the Consultant Pharmacist (CP)'s Medication Regimen Review (MRR). The DON explained the facility's medication pass time window allows for medications scheduled at 9 a.m. to be administered between 8 a.m. and 10 a.m., and those scheduled at 5 p.m. to be administered between 4 p.m. and 6 p.m. The DON acknowledged the CP's recommended administration times needed clarification, as they overlapped with other scheduled oral medications given daily at 9 a.m., and twice daily at 9 a.m. and 5 p.m., according to the facility's medication pass schedule.A review of the facility's CP's MRR, dated June 27, 2025, the MRR for Resident 39 indicated: .Cholestyramine (Questran) significantly interacts with other medications by preventing their absorption. The manufacturer indicates it should be given 1 hour after other meds in order to avoid these potential interactions. Please consider giving at 10am (1000) & 6pm (1800) instead.On July 22, 2025, at 2:45 p.m., during a concurrent interview with the CP, the CP acknowledged the recommended

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for one of five residents (Resident 69), when the nursing staff failed to clarify Resident 69's physician's order for lidocaine (medication for pain) 4% (percent, a unit of measurement for concentration) transdermal (topical) patches that directed application twice daily and failed to apply and remove the patch in accordance with both the physician's order and the manufacturer's instructions.This deficient practice had the potential to result in ineffective pain management, medication administration errors and compromised treatment outcomes as well as excessive lidocaine exposure and avoidable side effects such as skin irritation. Findings:On July 23, 2025, during a review of Resident 69's medical record, the admission Record indicated Resident was admitted to the facility on [DATE], with diagnoses which included dementia (loss of memory), major depressive disorder (depression), anxiety, osteoporosis (bones become weak and likely to break), osteoarthritis (tissues in the joint break down over time), difficulty in walking, and history of falling.A review of Resident 69's physician's order, dated June 28, 2025, indicated lidocaine 4% patch, with directions to apply to lower back topically two times a day for pain. Apply on lower back at 9 a.m. for 12 hrs (hours) and off at 2100 (9 p.m.) for 12 hours.A review of Resident 69's Medication Administration Record (MAR), dated June 2025 and July 2025, the MAR indicated nursing staff removed the lidocaine 4% patch at 9 a.m. on the following dates:- June 30, 2025;- July 1, 4, 8, and 22, 2025.A review of Resident 69's MAR, dated June 2025 and July 2025, the MAR indicated nursing staff applied the lidocaine 4% patch at 9 p.m. on the following dates:- June 27, 2025;- July 2, 5, 6, 14, 15, 16, 17, 18, and 20, 2025.During a review of Resident 69's MAR, dated July 2025, the MAR indicated the lidocaine 4% patch was applied to Resident 69 twice a day at 9 a.m. and 9 p.m. on the following dates:- July 2, 5, 6, 14, 15, 16, 17, 18, and 20. 2025On July 24, 2025, at 3:40 p.m., during a review of Resident 69's medical record with the Director of Nursing (DON), Resident 69's physician's order and the MAR were reviewed. The DON confirmed the findings and stated the lidocaine 4% patch should have been administered once daily, applied at 9 a.m. and removed at 9 p.m., as ordered by the physician. The DON acknowledged nursing staff should have clarified the frequency of the order with the physician and followed the correct application and removal times.A review of the facility's policy and procedure titled, Administering Medications dated April 2019, indicated, .Medications are administered in accordance with prescriber orders.If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns.A review of a nationally recognized drug information resource from Micromedex, dated on July 23, 2025, the resource indicated, .Lidocaine.Dosing/Administration.(Patch 4%) Apply 1 patch topically to affected area up to 12 hours.

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications in accordance with the facility's policies and procedures and/or manufacturer's instructions when:1. One discontinued and expired medication for Resident 107 was stored in Medication Refrigerator in Medication room [ROOM NUMBER] along with other active medications available for use;2. A total of four IV (intravenous, into a vein) Mini-Bag Plus containers, removed from manufacturer's overwrap, were stored without beyond use dates (BUD, date or time after which the product may not be used) in IV Emergency Kit (E-kit, a sealed container with various medications for use in emergencies) in Medication room [ROOM NUMBER]; and3. One expired inhaler for Resident 71 was stored in Medication Cart 1.These failures had the potential for residents to receive discontinued, expired, or ineffective medications, leading to medication errors and compromised treatment outcomes.Findings:1. On July 22, 2025, at 9:19 a.m., during an inspection of the Medication Refrigerator in the Medication room [ROOM NUMBER] with Registered Nurse (RN) 1, one bag of compounded Total Parenteral Nutrition (TPN - nutrition given through an IV) was observed to be expired. The pharmacy-applied label on the bag indicated Do Not Use After: 7/2/25 (July 2, 2025), 3 pm.During a concurrent interview, RN 1 confirmed the expiration date on the medication label and stated the TPN medication order for Resident 107 had been discontinued, and the resident had been discharged . RN 1 further stated the TPN bag should have been removed from the medication refrigerator and placed in the pharmaceutical bin for disposal.During a review of Resident 107's medical record, the physician's order, dated July 7, 2025, indicated the TPN medication order was discontinued on July 7, 2025, at 4:33 p.m.On July 22, 2025, at 10:15 a.m., during an interview with the Director of Nursing (DON), the DON stated the licensed nurse should have removed medication from the refrigerator for disposal when the order was discontinued. A review of the facility's policy and procedure titled, Discontinued Medication, dated April 2007, indicated: Staff shall destroy discontinued medications.in accordance with facility policy.Discontinued medications must be destroyed.in accordance with established policies.A review of the facility's policy and procedure titled, Discontinued Medications, dated January 9, 2025, indicated: .All discontinued medication must be labeled and stored in a secure location.Discontinued or on hold medications (accountable or not accountable) shall be given to the facility designate upon discontinuation (DON, etc.) and placed in a secured location.A review of the facility's policy and procedure titled, Storage of Medication, dated January 9, 2025, indicated: .All medications on hand for discharge or expired residents shall be immediately withdrawn from stock and either destroyed or locked away separately in conformance with medication destruction procedure.A review of the facility's policy and procedure titled, Destruction of Non-Accountable Medications, dated January 9, 2025, indicated: .A licensed nurse will remove discontinued non-controlled medication from stock, Attach D/C date sticker to medication.with date, Discontinued medication will be stored in the designated locked area awaiting disposition/return. Routinely licensed personnel will list discontinued medications on the appropriate log and package the medication in preparation for disposal. 2. During an inspection of an IV E-kit labeled IV EKIT #13, stored in the Medication Room in Nursing Station 2 on July 22, 2025, at 9:38 a.m. with RN 2, two 50 mL (milliliter - unit of measurement) bags and two 100 mL [NAME]'s (name of manufacturer) 0.9% Sodium Chloride IV Mini-Bag Plus containers (sterile IV bags containing a solution of salt and water, designed for easy mixing and administration of IV medication) were observed removed from the manufacturer's original overwrap packaging. These bags did not have BUD labeled as recommended by the manufacturer once the overwrap is removed.During a concurrent interview with the RN 2, RN 2 acknowledged none of the IV Mini-Bag Plus containers were labeled with a use-by date or BUD.On July 22, 2025, at 3:05 p.m., during a concurrent interview and record review with the DON, the DON stated the pharmacy had informed the BUD of 15 days for 50 mL bags and 30 days for 100 mL bags of Mini-Bag Plus containers after being removed from the overwrap. The DON also provided a pharmacy-supplied document titled ASHP Guidelines on Compounding Sterile Preparations, published in 2022 by the American Society of Health-System Pharmacists (ASHP), a national professional organization representing pharmacists in hospitals and health systems. The document included Table 10, which indicated a BUD of 15 days from the date the diluent (bag containing solution) was removed from the overwrap, for [NAME] Mini-Bag Plus containers, both 50 mL and 100 mL bags, when stored at room temperature, unless otherwise specified by the manufacturer. The DON acknowledged the BUD information.A review of the facility's policy

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the cook (Cook 1) followed the recipe for pureed (blend food into soft consistency) vegetables.This failure has the potential to affect the consistency, taste, and nutritive value of the pureed menu items, and further affect the resident's overall health condition.Findings:On July 23, 2025, at 11:00 a.m., a kitchen observation with a concurrent interview was conducted with [NAME] 1. [NAME] 1 stated there were 18 residents on a puree diet and that she had already prepared the pureed foods at 10:00 a.m.Cook 1 stated she followed the recipe book for pureed foods. [NAME] 1 stated when she prepared the pureed vegetables, she added two cups of water. Observed [NAME] 1 stirring the pureed vegetables, and noted the consistency of the pureed vegetables was more liquid than pudding consistency. [NAME] 1 was then observed pouring powder directly from a plastic clear container to the pureed vegetables without measuring. [NAME] 1 stated that she put 1.5 cups of thickener in the pureed vegetables (used to change the texture of food).On July 24, 2025, at 11:15 a.m., a concurrent interview and record review was conducted with [NAME] 1. [NAME] 1 stated that she followed the recipe book when pureeing food and when adding thickener to the food.The undated facility document titled, RECIPE: PUREED VEGETABLES, indicated that a serving of 6 (six) has a maximum of 1/3 cup (one third) of fluid and serving of 12 has a maximum of 3/4 (three fourths) cup of fluid. For commercial instant food thickener, it also indicated that a serving of 6 has a maximum of 6 tbsp (tablespoons - unit of measurement) and that a serving of 12 has a maximum of 12 tbsp.Cook 1 stated she did not follow recipe for pureed vegetables or food thickener use. [NAME] 1 stated that she exceeded the menu recipe's requirement for pureed food and thickener use.On July 24, 2025, at 11:40 a.m., the Dietary Supervisor (DS) was interviewed. The DS stated that [NAME] 1 should have followed the recipe for thickener and pureed foods. The DS stated the thickener added to the pureed food should have been measured. The DS stated not following the recipe for puree food and as well as not measuring thickener being added to the pureed food could affect the texture, taste, and nutritional value of food.A review of the facility's document titled, REGULAR PUREED DIET, dated 2023, indicated, .The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of food should be of a smooth and moist consistency and able to hold its shape .Detailed recipes and procedures for pureeing foods may be found in Binder #1 .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure sanitary conditions were maintained in the food and nutrition services and food were stored in accordance with professional standards for food service safety when: 1.Outside food items were not stored past the store by date and properly labeled according to the facility's policy and procedure; and2.The [NAME] did not disinfect the food thermometer in between use.These failures had the potential to cause food borne illness and food poisoning within their resident population.Findings:1.On July 24, 2025, at 3:50 p.m., an observation with a concurrent interview was conducted with the Dietary Supervisor (DS). The designated shared residents' refrigerator located in the conference room was inspected. The DS stated residents were allowed to store personal food in the designated shared refrigerator. The DS stated food was allowed to stay for three days in the refrigerator and the food item should be dated and labeled with the resident's name and room number upon storage.Signage was observed posted on the refrigerator door indicating, .Don't leave food for more than 48hrs (48 hours).The refrigerator is emptied out and cleaned every Friday.Stored inside the refrigerator were several mislabeled food items including:- One undated and unlabeled glassware container with food; the food item appeared frozen upon inspection;- One undated (name of restaurant) bag of food; the bag of food was labeled with resident's name and room number;- One undated bag of chips;. the bag of food was labeled with the resident's name;- One undated bag with leftover chicken; the bag of food was labeled with the resident's name;- One undated bag of leftover chicken; the bag of food was labeled with a room number;- One undated (name of restaurant) bowl of leftovers; the bowl of food was labeled with the resident's name;- One undated white glassware with rice;- One unlabeled and undated blue container with food;- One undated white and blue THANK YOU bag of food; the bag of food was labeled with the resident's name and room number;- One unlabeled and undated tub of dark chocolate peanut butter cups;- One undated and unlabeled bottle of (brand of milk) reduced fat milk;- One undated (name of drink) bottle;- One unlabeled and undated tub of sour cream with an expiration date of 7/7/25 (July 7, 2025); and- One undated bottle of (brand of drink); the bottle was labeled with the resident's first name; the bottle was opened and appeared to be frozen. The DS stated these outside personal food items should have been discarded. The DS stated the staff should have labeled the residents' food items with their name, room number, and the date.The DS stated there was a potential for the residents to get sick from the expired food. The DS stated it was a food safety concern due to the potential for food-borne illness and poisoning. The DS further stated she should have checked the refrigerator.A review of the facility's policy and procedure titled, Foods Brought by Family/Visitors, revised October 2017, indicated, .Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from the facility-prepared food.Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date.The nursing staff will discard perishable food on or before the use by date.The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates).2. On July 23, 2025, at 12 p.m., an observation with [NAME] 1 was conducted. [NAME] 1 was observed measuring the food cooking temperatures of each individual food item on the steam table prior to the tray line assembly.Cook 1 was observed to not consistently wipe the thermometer with a paper towel and/or alcohol swab between the measuring of temperatures between food items. [NAME] 1 was observed to be inconsistently using the same paper towel and/or alcohol swab to wipe off the food residue from the thermometer prior to taking the temperature of the food item.On July 24, 2025, at 11:15 a.m., [NAME] 1 was interviewed. [NAME] 1 stated that when taking temperature of foods prior to tray line, she must clean with tissue and then with an alcohol swab each time between foods.On July 24, 2025, at 11:40 a.m., the Dietary Supervisor (DS) was interviewed. The DS stated the food thermometer should be wiped with a paper towel and disinfected with an alcohol swab after a temperature is taken and before moving onto the next food.The DS stated that she saw [NAME] 1 only wipe the thermometer with a paper towel and did not disinfect it each time she proceeded to take the food temperature of the next food item. The DS stated not disinfecting the food thermometer prior to using it on the next food item can result in cross contamination of food, food allergies complications, and may alter the taste of the food.The facility's policy titled, THERMOMETER USE AND CALIBRATION, dated 2023, was reviewed. It indicated, when using the same thermometer on different foods during one meal, wipe the

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	055255	A. Building B. Wing	07/24/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were upheld when:1. One licensed nurse was observed wearing long, acrylic nails while providing direct patient care;2. One licensed nurse was observed not to follow enhanced barrier precautions (EBP- a type of isolation precaution) while providing direct patient care to Resident 45; and3. For Resident 44, the nebulizer tubing and mask, as well as the Yankauer suction tip (type of suction tip), were not stored appropriately when not in use.These failures had the potential to spread infection among the vulnerable residents of the facility. Findings: 1. On July 23, 2025, at 12:30 p.m., the medication cart was observed in front of room [ROOM NUMBER] and Licensed Vocational Nurse (LVN) 3 was observed coming out of the room after a few minutes. In a concurrent interview, LVN 3 stated she finished with her medication pass (administration) and the task entailed checking blood sugars and administering insulin for the 11 am med pass. LVN 3 was observed wearing long, red acrylic nails, approximately 1/3 inch from the tip of her fingers on all five fingers of the left hand, as well as the thumb, forefinger and third digit of the right hand. LVN 3 confirmed she was wearing acrylic nails, and the acrylic nails were placed on top of her natural nails since her natural nails were brittle. LVN 3 stated she was not sure what the facility policy was regarding acrylic nails, but acknowledged that nails should be kept short and clean. LVN 3 stated having long nails while providing direct patient care increased the risk of transmission of infection to the residents. LVN 3 stated she should not be wearing long, acrylic nails. On July 24, 2025, at 9:40 a.m., the Infection Preventionist (IP) was interviewed. The IP stated LVN 3 should not have worn long acrylic nails, since long and artificial nails were not allowed due to high risk of infection transmission to residents. The IP further stated long nails can also cause skin tears in the residents, which in turn, could also get infected. On July 24, 2025, at 2:15 p.m., the Director of Nursing (DON) was interviewed. The DON stated LVN 3 should not have had long acrylic nails. The DON further stated he expected direct patient care staff to have short clean nails and not have artificial nails, to avoid scratching the residents and potentially transmitting infection among the residents. A review of the facility’s “EMPLOYEE HANDBOOK,” dated November 1, 2014, indicated, “…Appearance Standards…Fingernails must be kept clean…” The facility did not have a policy specific to long, artificial nails in relation to infection control. According to the Centers for Disease Control and Prevention (CDC - a leading national public health institute in the United States) website, .Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and hand washing. It is recommended that healthcare providers do not wear artificial fingernails or extensions when having direct contact with patients at high risk .Keep natural nail tips less than 1/4 inch long. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On July 21, 2025, at 10:50 a.m., an observation was conducted with Resident 45. Resident 45 was in bed, alert, non-verbal, and appeared congested. Outside Resident 45’s room was a signage indicating EBP before entering. The EBP sign indicated, “EVERYONE MUST: Perform hand hygiene before entering the room…ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: [NAME] (put on) gown and gloves…Device care or use…Change and discard gown and gloves and perform hand hygiene between each resident and before leaving room…” On July 21, 2025, at 10:55 a.m., LVN 3, was observed to enter Resident 45’s room. LVN 3 donned gloves and proceeded to suction (clear out airway) Resident 45’s airway. LVN 3 did not don a mask and/or gown prior to suctioning Resident 45’s airway. On July 21, 2025, at 11:55 a.m., LVN 3 was interviewed. LVN 3 stated Resident 45 was experiencing oxygen desaturation (decrease in oxygen concentration level in blood) and subsequently, required suctioning and breathing treatment. LVN 3 stated Resident 45 was on EBP due to her gastrostomy tube (tube inserted through abdomen to stomach for nourishment). LVN 3 stated EBP was indicated for residents with a gastrostomy tube to protect both the residents and staff from possible spread of infection. LVN 3 stated the facility staff should wear PPE (personal protective equipment) such as gown, gloves, and mask when providing direct care when providing direct care to a resident requiring EBP precaution. LVN 3 stated airway suctioning on a resident was considered direct care. LVN 3 stated she did not wear gown and mask when she conducted the airway suctioning on Resident 45. LVN 3 stated she did not follow the procedure on EBP precaution. On July 22, 2025, Resident 45’s record was reviewed. Resident 45 was admitted to the facility on [DATE], with diagnoses which included Alzheimer’s (memory loss), diabetes mellitus (abnormal blood sugar), and presence of gastrostomy tube. A review of Resident 45’s physician’s order, dated May 13, 2024, which indicated, “May have enhanced barrier precaution r/t (related to) Gtube (gastrostomy tube) used to minimized risk of MDROs (Multi-Drug Resistant Organism - microorganisms, such as bacteria, that have become resistant to multiple antibiotics). A [NAME] of Resident 45’s care plan, dated May 13, 2024, indicated, “…May have enhanced barrier precaution…Follow enhance barrier precaution when doing high contact activities with resident…” The facility's policy and procedure titled, “Enhanced Barrier Precautions,” dated 2001, was reviewed. The policy indicated, “…Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents…EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply…Gloves and gown are applied prior to performing the high contact resident care activity…Face protection may be used if there is also a risk of splash or spray…EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devise regardless of MDRO colonization…” 3. On July 21, 2025, at 11:07 a.m., an observation with a concurrent interview was conducted with Resident 44. Resident 44 was in bed, alert, and able to be interviewed. Observed next to Resident 44’s bed was a bedside dresser with Resident 44’s personal belongings. Observed behind a bouquet of flowers and directly placed on top of the bedside dresser were the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A nebulizer tubing and mask with a date of “6/30/25 (June 30, 2025)”; and - A suction machine set-up with tubing and Yankauer (a type of suction tip used in medical procedures to remove fluids and debris from a patient's airway or surgical site). The suction canister contained a clear liquid and did not indicate a label date. Both nebulizer tubing and mask, and suction tubing and Yankauer were observed not stored in the appropriate container bag when not in use. In a concurrent interview, Resident 44 stated her last breathing treatment (respiratory medication given through nebulizer) was five days ago. On July 21, 2025, at 12:04 p.m., an observation with a concurrent interview was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 observed the nebulizer tubing and mask and suction tubing and Yankauer directly on top of Resident 44’s bedside dresser. LVN 3 stated the nebulizer tubing and suction supplies should be changed every week. LVN 3 stated the nebulizer tubing was dated June 30, 2025, and the suction supplies (tubing, canister, and Yankauer) were undated. LVN 3 stated the nebulizer tubing and bag should have been replaced on July 20, 2025. LVN 3 stated the nebulizer tubing and mask, and suction tubing and Yankauer should have been stored in a bag when not in use to prevent the spread of infection. LVN 3 stated she did not know when the suction machine was last used. On July 24, 2025, at 3:03 p.m., the Infection Preventionist (IP) was interviewed. The IP stated the nebulizer tubing and mask should be changed once a week. The IP stated it was the facility’s standard of practice to change tubing (e.g. oxygen tube, nebulizer tube) on Sundays. The IP stated a suction canister should be discarded after each use. The IP stated the suction canister and Yankauer next to Resident 44’s bedside dresser, should have been dated if not used and the suction canister and Yankauer should have been discarded after use during the shift. The IP further stated the nebulizer tubing and mask, and suction tubing and Yankauer should have been stored in a bag when not in use. A review of the facility’s document titled, “Suctioning the Upper Airway (Nasopharyngeal or Oropharyngeal Suctioning,” revised October 2023, indicated, “…After Suctioning…Turn off suction…Disconnect catheter from tubing. Wrap catheter around gloved hand. Pull the glove off and over the catheter. Discard in designated receptacle…”