

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER Community Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4070 Jurupa Avenue Riverside, CA 92506	

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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on interview and record review, the facility failed to provide a notice of proposed discharge to one of three residents, Resident 2, when Resident 2 was discharged from the facility after being transferred to the general acute care hospital (GACH). In addition, the facility failed to notify the Long-Term Care (LTC) Ombudsman (an advocate for residents and families in long-term care facilities) and Resident 2's family member (FM) of Resident 2 ' s discharge from the facility.</p> <p>This failure placed Resident 2 at an increased risk of being discharged without having an advocate to ensure a safe and effective transition of care, or without having a clear understanding of his appeal and discharge rights.</p> <p>Findings:</p> <p>A review of Resident 2 ' s medical record was conducted on April 29, 2024. Resident 2 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (damage to tissues in the brain due to loss of oxygen to the area), hypertension (high blood pressure), depression (mood disorder that causes a persistent feeling of sadness and loss of interest), schizoaffective disorder (a mental health disorder), and convulsions (the condition of uncontrollable shaking of the body).</p> <p>Resident 2's Change of Condition Progress Notes, dated, March 27, 2024, at 9:10 p.m., indicated Resident 2 was transferred to the GACH due to being unresponsive.</p> <p>On April 29, 2024, at 3:23 p.m., an interview was conducted with the Admissions Director (AD). The AD stated Resident 2 was at the hospital and that Resident 2 had been medically cleared to return to the facility on [DATE]. The AD stated Resident 2 was not allowed back to the facility because he required isolation and there was no isolation bed available.</p> <p>On May 1, 2024, at 12:45 p. m., a record review with the Administrator (ADM) of Resident 2 ' s medical record was conducted. The ADM verified Resident 2's bed hold ended April 3, 2024, and that the facility initiated Resident 2's discharge on April 3, 2024. The ADM was unable to provide Resident 2's discharge notification documents from the facility. There were no notes or documents noted in PCC (computer application for documentation) that the facility informed Resident 2, Resident 2's FM, or the LTC Ombudsman of Resident 2's discharge from the facility on April 3, 2024.</p> <p>(continued on next page)</p>

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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NAME OF PROVIDER OR SUPPLIER Community Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4070 Jurupa Avenue Riverside, CA 92506	
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 1, 2024, at 12:55 p.m., in an interview with the Social Services Director (SSD), the SSD stated the facility initiated Resident 2 ' s discharge from the facility on April 3, 2024, and there was no documentation Resident 2 ' s FM or that the LTC Ombudsman was notified Resident 2 would not be returning to the facility.</p> <p>Further review of Resident 2's medical record was conducted. There was no documented evidence that a written notice of discharge was provided to the LTC Ombudsman or to Resident 2 ' s FM when Resident 2 was discharged from the facility on April 3, 2024.</p> <p>A review of facility document titled Transfer and Discharge (including AMA) revised December 19, 2022, indicated, . It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances . The facilities transfer/discharge notice will be provided to the resident and the residents representative in the language and manner in which they can understand .the facility will maintain evidence that the notice was sent to the Ombudsman . In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative before the discharge and must also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Notice to the Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative .</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on interview and record review, the facility failed to ensure, for one of three residents reviewed, Resident 2, who was transferred to General Acute Care Hospital (GACH) on March 27, 2024, was readmitted back to the facility on the first available bed.</p> <p>This failure resulted to a violation of Resident 2's right to be readmitted back to the facility to the first available bed and had the potential to cause emotional distress.</p> <p>Findings:</p> <p>On April 29, 2024, Resident 2's medical record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hypertension (high blood pressure), depression (a depressed mood or loss of pleasure or interest in activities for long periods of time), schizoaffective disorder (a mental health disorder that is marked by a combination of symptoms such as hallucinations or delusions), and convulsions (condition in which muscles contract and relax quickly causing uncontrolled shaking of the body).</p> <p>The document titled, SBAR Communication Form (a change of condition document) dated March 27, 2024, indicated Resident 2 was transferred to the GACH.</p> <p>A review of a document titled, WellSky (communication between the facility and the GACH), indicated attempts were made by the GACH from April 18, 2024, through April 29, 2024, to re-admit Resident 2 back to the facility.</p> <p>In an interview with the Director of Business Development (DBD) on April 29, 2024, at 3:10 p. m., the DBD stated the Case Manager (CM) at the GACH asked if there was a plan to receive Resident 2 back to the facility. The DBD stated beds were available, however Resident 2 needed an isolation room, which they did not have at the time. The DBD stated as of April 29, 2024, there was still no available room.</p> <p>In an interview with the Admissions Director (AD) on April 29, 2024, at 3:23 p.m., the AD stated Resident 2 was medically cleared to return to the facility on [DATE]. The AD stated Resident 2 was on isolation while in the GACH, but the facility did not have an isolation room for Resident 2 to return.</p> <p>On May 1, 2024, at 1:50 p. m., during a record review and interview with the Infection Preventionist (IP), the IP stated she tracked all infections in the facility and residents with like isolations can cohort (a group of people with a shared characteristic). The IP stated there was one resident isolated for the same reason Resident 2 required isolation, from April 17, 2024 until April 25, 2024. The IP stated two isolation rooms had been available since April 25, 2024. The IP stated the rooms could have been used for isolation for Resident 2. During a concurrent record review of the document titled, (Name of Facility) -In House (a document of the facility's daily census) indicated two rooms were available to use for isolation from April 25, 2024 until April, 29, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy titled, Readmission to Facility revised December 19, 2022, indicated, .Residents who seek to return to the facility after the expiration of the bed-hold period or when state law does not provide for bed-holds, are allowed to return to their previous room if available or immediately to the first available bed in a semi-private room provided the resident .Still requires the services provide by the facility, and . Is eligible for Medicare skilled nursing facility or Medicaid nursing facility services .</p>		