STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055409	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care and Rehabilitation Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on observation, interview, and record review, the facility failed to ensure for one of three residents (Resident 1), their family member was notified of Resident 1 's room change. This failure resulted in Resident 1 's Family Member, to be unaware of Resident 1's location within the facility. Findings: On March 6, 2025, at 9:26 a.m., during an interview, Resident 1 's Family Member (FM) 1 stated the facility did not notify FM 2 when they moved the resident to different rooms. On March 6, 2025, at 12:45 p.m., during a concurrent interview and observation, Resident 1 was in her current room, sitting in her wheelchair, wearing a neck brace. She was alert and conversant. Resident 1 stated she had remained in the same room since admission. A review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included neck fracture (a break in the bone) and need for assistance with personal care. FM 2 was the listed as the primary contact under the CONTACTS section of her record. A review of Resident 1's HISTORY AND PHYSICAL dated December 11, 2024, indicated she had decision-making capacity. A review of Resident 1's .Change in Condition Evaluation forms indicated that FM 2 was notified when Resident 1 had changes of condition on December 13, 2024, January 3, 9, and February 16, 2025. A review of Resident 1's Census tab on PointClickCare (PCC- an electronic healthcare record software) indicated Resident 1 was in room [ROOM NUMBER]-A on December 4, 2024, room [ROOM NUMBER]-B on December 11, 2024, and room [ROOM NUMBER]-B on February 19, 2025. There was no documented evidence that FM 2 was notified about Resident 1 ' s room change from room [ROOM NUMBER]-A to room [ROOM NUMBER]-B. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 7, 2025, at 3:28 p.m., during a concurrent interview with the Social Service Director (SSD), and a record review of Resident 1 ' s medical record, the SSD stated the resident is informed of room changes, and the FMs or whoever is listed as the responsible party, or was first on the contact list, is informed as well by phone call. She stated she documented the notification on a Notice of Room Change form. The SSD stated she did not notify FM 2 because Resident 1 was alert and oriented. On March 7, 2025, at 4:36 p.m., during an interview, the Director of Nursing (DON) stated the SSD should have notified FM 2 about Resident 1 's room change, and she should have documented it in Resident 1 's medical record. A review of the facility's policy and procedure titled Change of Room or Roommate dated December 19, 2022, indicated . Prior to making a room change . all persons involved in the change/assignment, such as residents and their representatives, will be given notice of such change as possible . The Social Service designee or Licensed Nurse should inform the resident's sponsor/family in advance of a change in the residents' room . A review of the facility's policy and procedure titled Notification of Changes dated December 19, 2022, indicated . The facility must inform the resident, consult with the resident's physician and or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include . A change of room or roommate assignment .

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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 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** 48240 Based on observation, interview, and record review, the facility failed to ensure for one of three residents, Resident 1, that her open wound was assessed and treated after she informed a staff member about it. This failure resulted in the delay of assessment and treatment of Resident 1 's open wound and had the potential for the wound to become infected. Findings: On March 6 and 7, 2025, unannounced visits were conducted at the facility. On March 6, 2025, at 12:45 p.m., during a concurrent interview and observation in her room, Resident 1 was sitting in her wheelchair, wearing a neck brace. She was alert and conversant. Resident 1 stated she had wounds on her right lower leg and the dressing (a covering, often a bandage or pad, used to protect a wound and promote healing) had been changed earlier that day. Resident 1 also stated she bumped her left leg at the clinic where she had her CT scan (Computed Tomography scan- a medical imaging technique that reveal detailed images of the inside of the body) done either Monday (March 3, 2025) or Tuesday (March 4, 2025). Resident 1 was observed with a wound dressing on her left leg. Resident 1 couldn't say who placed the wound dressing on her left leg. A review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included neck fracture (a break in the bone) and the need for assistance with personal care. A review of Resident 1's HISTORY AND PHYSICAL dated December 11, 2024, indicated she had decision-making capacity. A review of Resident 1's care plan titled, Resident 1 .is at continued risk for breakdown r/t (related to) .fragile skin was initiated on December 5, 2024, and revised on March 6, 2025, indicated interventions such as . Follow facility policies/protocols for the prevention/treatment of skin breakdown . There was no documented evidence that Resident 1 's physician was notified about the open wound on her left leg or that a treatment was initiated on March 3, 4, or 5, 2025. On March 6, 2025, at 2:00 p.m., during a concurrent observation of Resident 1 and an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had skin tears on her right lower leg, and they were providing treatment for those. LVN 1 stated Resident 1 had a wound dressing on her left leg, and he did not know why. LVN 1 was asked to remove the wound dressing. Resident 1 had an open wound that measured approximately the size of a nickel, with redness around the edges, a yellowish wound bed (the base or open area of a wound), and some scabbing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 6, 2025, at 2:42 p.m., during an interview with Certified Nursing Assistant (CNA) 1, she stated that Resident 1 informed her of a bump she had on her left leg on March 5, 2024, she notified LVN 2 and recorded it on the shower sheet. CNA 1 stated LVN 2 also signed the shower sheet. A review of the shower sheets from March 3, 4, and 5, 2025, indicated there was no documented evidence that CNA 1 reported Resident 1 ' s left leg wound to LVN 2. On March 6, 2025, at 3:42 p.m., during a telephone interview, LVN 2 stated she couldn't recall if she received a report about Resident 1 's left leg wound. LVN 2 stated if she received report that a resident had a new skin problem, she would initiate a change of condition report, notify the MD (medical doctor) and family, obtain a treatment order, and initiate a care plan on the same day. On March 7, 2025, at 4:36 p.m., during an interview, the Director of Nursing (DON) stated if a nurse was informed of any skin problem, the nurse should assess the resident ' s skin, verify the skin problem, notify the physician and family, and obtain a treatment order. The DON stated there was no documented evidence inResident 1 's medical record indicating Resident 1 's wound on the left leg was addressed on March 5, 2025. The DON stated if Resident 1's left leg wound was not addressed, her wound could have gotten bigger, and infected. A review of the facility's policy and procedure titled, Skin assessment dated [DATE], indicate .change of condition .Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions .Documentation of skin assessment .Include date and time of the assessment, your name, and position title. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.) . Document type of wound .Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) .Document other information as indicated or appropriate .

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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. 48240 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when Certified Nurse Assistant (CNA) 2 did not wear the appropriate personal protective equipment (PPE - specialized clothing or equipment worn to create a barrier between healthcare workers and potential sources of infection, like blood, body fluids, or other potentially infectious materials) when she entered the room of a COVID-19 (a highly contagious respiratory disease) positive resident. This failure had the potential to spread COVID-19 to other residents. Findings: On March 7, 2025, at 11:22 a.m., during an observation outside Resident 2's room, there were signs by the door indicating .CONTACT PRECAUTIONS .EVERYONE MUST Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO .Put on gloves before room entry .Put on gown before room entry .DROPLET PRECAUTIONS .EVERYONE MUST .Make sure their eyes, nose and mouth are fully covered before room entry . On March 7, 2025, at 11:25 a.m., during a concurrent observation and interview, Resident 2 was in her room, lying in bed, alert and conversant. Resident 2 stated she just found out earlier she tested positive for COVID-19. Resident 2 pressed on the call light because she wanted a chocolate protein drink. On March 7, 2025, at 11:28 a.m., CNA 2 was observed entering Resident 2's room wearing only surgical mask and gloves. On March 7, 2025, at 11:32 a.m., during an interview, CNA 2 stated she entered Resident 2's room wearing a surgical mask and gloves. CNA 2 stated she did not notice the signs at the door. CNA 2 stated she should have worn goggles, an N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) mask, gown, and gloves before entering Resident 2's room to prevent contamination and spread of infection. On March 7, 2025, during an interview, the Infection Preventionist Nurse stated when there are contact and droplet precaution signs at the resident's door, the staff are expected to perform hand hygiene and wear necessary PPE such as gown, gloves, face shield and N95 mask. On March 7, 2025, at 4:36 p.m., during an interview, the Director of Nursing (DON) stated CNA 2 should have worn the proper PPE to help prevent the spread of COVID-19 and to protect herself and other residents. (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 the facility's policy and procedure titled, Personal Protective Equipment dated December 19, 2022, indicated .This facility promotes appropriate use of personal protective equipment to prevent the transmission of pathogens to residents, visitors, and other staff .All staff who have contact with residents and/or their environments must wear personal protective equipment as appropriate during resident care activities and at other times in which exposure to blood, body fluids, or potentially infectious materials is likely . A review of the facility's policy and procedure titled, Coronavirus Prevention and Response dated December 19, 2022, indicated .HCP (healthcare professional) who enter the room of a resident with suspected or confirmed SARS-CoV-2 (COVID-19) infection should adhere to standard precautions and use a .respirator with N95 filters or higher, gown, gloves, and eye protection .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on observation, interview, and record review, the facility failed to ensure the call light was functioning for one of three residents, Resident 3. This failure resulted in Resident 3 waiting for a long time to be assisted with toileting hygiene. Findings: On March 7, 2025, at 10:30 a.m., during a concurrent observation and interview, Resident 3 was in her room, lying in bed, wearing a neck brace. She was alert and conversant. Resident 3 stated on the evening of March 5, 2025, she pressed on her call light because she needed to be changed and she waited for a long time, about three or four hours and she was even banging on the wall, but nobody came to her until her daughter called the facility. Resident 3 stated that when the Certified Nursing Assistant (CNA) came to change her, the CNA informed her that her call light had malfunctioned, the light bulb outside her room was not lighting up. Resident 3 stated she was not provided with an alternative method to call out for help that night. Resident 3 stated she was now being checked hourly after her daughter spoke to the staff once again. A review of Resident 3's medical record indicated she was admitted to the facility on [DATE], with diagnoses which included nasal (nose) and occipital (base of the skull) fracture (a break in the bone) and need for assistance with personal care. A review of Resident 3's History and Physical Exam dated March 20, 2025, indicated Resident 3 has the capacity to understand and make decisions. A review of Resident 3's Minimum Data Assessment (an assessment tool) dated March 25, 2025, indicated Resident 3 required substantial/maximal assistance with toileting hygiene. On March 7, 2025, at 1:45 p.m., during a telephone interview, CNA 3 stated she was assigned to care for Resident 3 on March 5, 2025, for the evening shift (3:00 p.m. to 11:00 p.m.). She stated she never saw Resident 3's call light on. CNA 3 stated she was attending to another resident when she was informed that Resident 3 had been asking for help and the family had called the facility about it. CNA 3 stated Resident 3 was on isolation because of COVID-19, and she popped her head inside her room and informed Resident 3 that she was just finishing up providing care to another resident. CNA 3 stated when she attended to Resident 3, 30 to 40 minutes after she was informed that Resident 3 was asking for help, she checked her call light and found out the call light bulb outside the room did not turn on when the call light was pressed. CNA 3 stated she informed Registered Nurse (RN) 1. CNA 3 stated Resident 3 was provided with more frequent checks than usual. CNA 3 stated she did not document that she frequently checked Resident 3 that night. CNA 3 stated she did not check if Resident 3's call light was functioning in the beginning of her shift. On March 7, 2025, at 4:18 p.m., during an interview with RN 1, RN 1 stated CNA 3 informed her that Resident 3's call light had malfunctioned, and she wrote it on the maintenance log, the next shift was made aware, and she was placed on frequent visual checks. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 19, 2025, at 2:10 p.m., during a telephone interview, the Director of Nursing (DON) stated the CNAs and Licensed Nurses are responsible for ensuring the residents' call lights are functioning. The DON stated when the staff knew that Resident 1's call light had malfunctioned, they should have switched out call lights from other rooms or transferred Resident 1 to a different room. The DON stated the facility did not have any policy when there is a call light malfunction.