| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055409 | A. Building<br>B. Wing | 02/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Community Care and Rehabilitation Center | 4070 Jurupa Avenue<br>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 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**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 was followed for one of three residents (Resident 1) when Resident 1's request to be discharged , and the facility's referral and coordination with a placement agency were not documented in the medical records.This failure had the potential to result in an inappropriate discharge.Findings:A review of Resident 1's admission Record indicated he was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (a change in how your brain works due to an underlying condition), and Alzheimer's disease (a loss of cognitive functioning - thinking, remembering, and reasoning).A review of Resident 1's Social Service Assessment dated December 12, 2025, indicated Resident 1 was anticipated to have a short term stay in the facility.A review of Resident 1's History and Physical dated December 13, 2025, indicated he had the capacity to understand and make decisions.A review of Resident 1's Interdisciplinary Care Conference dated December 23, 2025, indicated Resident 1 attended the conference and his discharge plan was to be discharged to a room and board.A review of Resident 1's Progress Note dated January 15, 2026, indicated he was discharged to (name and address of room and board) with home health registered nurse evaluation and treatment to follow.Further review of Resident 1's medical record indicated there was no documented evidence of the events leading to Resident 1's discharge.On January 28, 2026, at 10:10 a.m., during an interview, the Social Service Assistant (SSA) stated she assists residents with finding placement to a lower level of care. She coordinates home health, durable medical equipment and places an order for more medication when needed. The SSA further stated the facility utilizes placement agencies to assist with finding placement for the residents in the facility. The SSA stated the representatives of placement agencies come into the facility to see the residents and provide information.The SSA stated Resident 1 was adamant about going home and wanted to find placement. The SSA stated she referred Resident 1 to a placement agency representative (PAR). The SSA stated the PAR discussed options with Resident 1. The SSA stated the PAR found a room and board for Resident 1 and Resident 1 agreed with that placement. On January 28, 2026, at 12:17 p.m., during an interview, the SSA stated she did not document that Resident 1 was adamant about leaving the facility, or that she referred and coordinated placement with the PAR. The SSA stated Resident 1 asked her everyday about leaving the facility. On January 28, 2026, at 3:25 p.m., during an interview, the SSA stated she should have documented the discharge process for Resident 1, including his request to be discharged and communication she had with the PAR.On February 9, 2026, at 3:30 p.m., during an interview, the Director of Nursing (DON) stated he does not know if the SSA documented Resident 1's request for discharge and referral to the placement agency. The DON stated, as long as the resident is agreeable to the discharge and there is a care plan, it would be enough.A review of the facility's policy and procedure titled, Discharge Planning Process dated December 29, 2022, indicated .The facility will document any referrals to local contact<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | agencies or other appropriate entities made for the purpose of the resident's interest in returning to the community .The facility will update a resident's comprehensive care plan and discharge plan as appropriate, in response to the information received from referrals to a local contact agencies or other appropriate entities .The evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record . |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, for one of three residents, Resident 2, clinical findings demonstrating the necessity of inserting an indwelling Foley catheter (IFC- a thin, hollow tube inserted through the urethra into the urinary bladder to collect and drain urine) were documented in the medical record. In addition, the facility failed to initiate a care plan addressing Resident 2's use of IFC.This failure had the potential for unnecessary use of an IFC and resulted in Resident 2 having a urinary tract infection.Findings:A review of Resident 2's medical records indicated he was initially admitted to the facility on [DATE], with diagnoses which included right-sided muscle weakness and paralysis following cerebral infarction (blocked blood flow to the brain).A review of Resident 2's History and Physical dated June 16, 2025, indicated the resident can make needs known but cannot make medical decisions.A review of Resident 2's Minimum Data Set (an assessment tool) dated July 22, 2025, indicated he was always incontinent (no voluntary control of urine) to bladder function and did not have an indwelling catheter. A review of Resident 2's Physician's Orders indicated the following:-On October 8, 2025, Indwelling Catheter care- cleanse urethral meatus (exit point for urine) with soap and water, rinse & pat dry every day shift for Urinary retention was entered by Licensed Vocational Nurse (LVN) 1 and was later discontinued on October 23, 2025;-On October 15, 2025, Indwelling Catheter: Foley Catheter Size 16Fr (French scale referring to the size of the catheter) Balloon Size 10 CC (cubic centimeter - a unit of measurement) Change for blockage, leaking, pulled out, excessive sedimentation (particles in fluid). Change catheter drainage bag as needed and with every change of indwelling catheter as needed, and was later discontinued on October 23, 2025.-On October 23, 2025, Indwelling Catheter care- cleanse urethral meatus with soap and water, rinse & pat dry every day shift for NEUROGENIC BLADDER, and Indwelling Catheter: Foley Catheter Size 16Fr Balloon Size 10 CC Change for blockage, leaking, pulled out, excessive sedimentation. Change catheter drainage bag as needed and with every change of indwelling catheter as needed for NEUROGENIC BLADDER (nerve damage of urinary system leading to inability to properly store or empty urine).A review of Resident 2's Care Plan Report did not indicate a care plan for the IFC use was initiated.Further review of Resident 2's medical record indicated there was no documented evidence of clinical findings supporting urinary retention and neurogenic bladder, and the necessity for IFC use. Resident 2 was transferred to the general acute care hospital (GACH) on January 7, 2026, for altered mental status, and did not return to the facility.A review of Resident 2's GACH Notes titled, Emergency Provider Report dated January 7, 2026, indicated Resident 2 was lethargic on evaluation with IFC in place, draining yellow urine with sediment, the urinalysis showed signs of infection and Resident 2 was admitted for altered mental status secondary to urinary tract infection.On February 29, 2026, at 11:36 a.m., during an interview, Certified Nurse Assistant (CNA) 1 stated she was familiar with Resident 2. CNA 1 stated Resident 2 had an IFC for a while and he was recently transferred to the hospital with the IFC in place. CNA 1 stated she did not know why Resident 2 had an IFC.On February 5, 2026, at 1:44 p.m., during a concurrent interview with LVN 1 and record review of Resident 2's medical records, LVN 1 stated residents may need to have an IFC inserted for urinary retention, or they may have a diagnosis requiring it. LVN 1 stated he couldn't remember why Resident 2 needed an IFC, maybe one of the CNAs reported that Resident 2 did not have any urine output for eight hours. LVN 1 stated there was no documentation in Resident 2's medical record demonstrating why Resident 2 needed an IFC. LVN 1 stated he should have documented what happened with Resident 2 to show why he needed an IFC. On February 9, 2026, at 3:00 p.m.,<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | during an interview, the Director of Nursing (DON) was asked to review Resident 2's medical record, and if there was a care plan addressing Resident 2's use of an IFC. The DON stated he couldn't find any care plan. The DON stated if there was a change in the resident's urinary status, the licensed nurse should have done a change of condition, inform the family, inform the doctor, and initiate a care plan. A review of the facility's policy and procedure titled, Appropriate Use of Indwelling Catheters dated December 19, 2022, indicated .Any decision regarding the use of indwelling urinary catheter will be based on the resident's condition and goals for treatment .Documentation to support decision making will be included in the medical record, including but not limited to: clinical or medical conditions demonstrating the need for an indwelling urinary catheter .the plan of care will address the use of and indwelling catheter including strategies to prevent complications . |