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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure three (3) of five (5) residents reviewed (Residents 4, 10, 182) were free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medications including venlafaxine (an antidepressant medication used for depression [mental health condition characterized by persistent feelings of sadness] , anxiety [human emotion characterized by feelings of unease, worry, or fear], and panic disorder [brief episode of intense anxiety, which causes the physical sensation of fear]) and Seroquel (an antipsychotic medication for bipolar disorder [disorder associated with episodes of mood swings ranging for depressive lows to manic highs], depression, and schizophrenia [chronic brain disorder that affects thinking, feeling, and behavior]) when:</p> <ol style="list-style-type: none"> <li>Residents 10 and 182 were administered venlafaxine without potential adverse effect monitoring documented during use of venlafaxine; and</li> <li>Resident 4 was administered Seroquel without manufacturer specified monitoring during use of Seroquel.</li> </ol> <p>These failures resulted in unnecessary medications for Residents 4, 10, and 182, which increased the potential for medication interactions, adverse reactions, and unidentified risks associated with the use of psychotropic medications that included but not limited to sedation, respiratory depression, constipation, anxiety, agitation, and memory loss.</p> <p>Findings:</p> <p>1a. A review of Resident 10's admission record indicated he was originally admitted to the facility on [DATE], and re-admitted to the facility on [DATE], with diagnoses which included depression.</p> <p>A review of Resident 10's medical record indicated he had been receiving Effxor (brand name for venlafaxine) XR (extended release, designed to release medicine slowly into to body over a prolonged period) in various doses since August 2024.</p> <p>A review of Resident 10's current Order Summary Report, dated May 9, 2025, indicated the following provider orders:</p> <p>. Effxor XR (venlafaxine) 75 mg (milligram, unit of measurement) one time a day for verbalization of feeling sad related to depression, dated May 1, 2025 .and</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Monitor for side effects related to use of psychotropic medications. My initials indicate absence of signs and symptoms of side effects, dated July 18, 2024 .</p> <p>During a concurrent interview and record review on May 8, 2025, at 11:55 a.m., with the Quality Assurance (QA) nurse, Resident 10's medical record was reviewed. When asked how nursing staff would know what side effects to monitor during the use of Effexor XR, the QA nurse stated side effects would have been listed on the resident's care plan. The QA nurse confirmed there was no care plan developed for depression and use of Effexor XR. The QA nurse acknowledged a care plan should have been developed. The QA nurse stated a care plan was needed for nursing staff to know how to manage side effects and evaluate the effectiveness of the medication.</p> <p>During an interview on May 8, 2025, at 4:19 p.m., with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to have monitored for side effects and to have developed a care plan to ensure there was a guide to care for the resident.</p> <p>1b. A review of Resident 182's admission record indicated she was initially admitted to the facility on [DATE] and then admitted again on May 4, 2025 with diagnoses which included depression.</p> <p>A review of Resident 182's current Order Summary Report, dated May 9, 2025, indicated a provider order for: venlafaxine 75 mg one time a day for verbalization of feeling sad related to depression, dated May 4, 2025.</p> <p>A review of Resident 182's clinical record on May 7, 2025, indicated there was no provider order to monitor side effects related to use of venlafaxine.</p> <p>During a concurrent interview and record review on May 8, 2025, at 12:11 p.m., with the QA nurse, Resident 182's medical record was reviewed. The QA nurse confirmed there was no provider order to monitor for side effects of venlafaxine and stated venlafaxine side effects would have been listed in the care plan. The QA nurse confirmed there was no care plan developed related to depression or use of venlafaxine. The QA nurse stated without a care plan nursing staff would not know what side effects to look for during use of venlafaxine.</p> <p>During an interview on May 8, 2025, at 4:22 p.m., with the DON, the DON acknowledged Resident 182 did not have a provider order to monitor for side effects related to the use of venlafaxine and stated there should have been an order to monitor for side effects. The DON stated the resident was re-admitted to the facility four (4) days ago and the policy was to develop a care plan within seven (7) days of admission.</p> <p>During a telephone interview on May 9, 2025 at 2:30 p.m. with the Consultant Pharmacist (CP) in the presence of the DON, the CP stated some of the potential side effects for venlafaxine that should have been monitored during the use were: sedation, dry mouth, and constipation.</p> <p>A review of the Prescribing Information (PI, detailed description of a drug's uses, doses, warnings, side effects, and drug-drug interactions) for venlafaxine tablets, dated April 2024, retrieved from DailyMed (a public website maintained by the U.S. Food and Drug Administration), indicated, Most common adverse reactions .nausea, somnolence (drowsiness), dry mouth, sweating .anorexia (loss of appetite), constipation .</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A review of the facility's policy and procedures titled Use of Psychotropic Medication, date revised December 19, 2022, indicated, The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record.</p> <p>2. A review of Resident 4's admission record indicated she was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included schizoaffective disorder (mental health condition characterized by psychotic symptoms like hallucinations/delusions and mood episodes like mania or depression).</p> <p>A review of Resident 4's medical record indicated she had been receiving Seroquel in various doses since February 2022. Resident 4's current Order Summary Report, dated May 9, 2025, indicated a provider order for: Seroquel 100 mg two times a day for visual hallucinations related to schizoaffective disorder, dated January 20, 2025.</p> <p>During a concurrent interview and record review on May 8, 2025, at 12:14 p.m., with the QA nurse, Resident 4's medical record was reviewed. The QA nurse confirmed Resident 4 was initially started on Seroquel on February 15, 2022. The QA nurse was unable to locate documentation of manufacturer's specified monitoring for lipids (blood cholesterol levels), TSH (a thyroid hormone), and Free T4 (the active form of the thyroid hormone in the blood). The QA nurse stated she would follow-up with medical records.</p> <p>During a follow-up interview on May 8, 2025, at 2:35 p.m. with the QA nurse, she verified no documentation of manufacturer's specified monitoring (lipids, TSH, or Free T4) during Seroquel use was found in Resident 4's medical records.</p> <p>During a concurrent interview and record review on May 8, 2025, at 4:38 p.m., with DON, the DON acknowledged there was no documentation of the manufacturer's specified monitoring (lipids, TSH, or Free T4) during Seroquel use in Resident 4's medical records.</p> <p>During a telephone interview on May 9, 2025, at 2:30 p.m. with the CP in the presence of the DON, the CP acknowledged Resident 4 did not have documentation of manufacturer specified monitoring (lipids, TSH, or Free T4) during Seroquel use and stated it should have been monitored.</p> <p>A review of the PI for Seroquel, dated January 2025, provided by the facility, indicated, .fasting blood lipid testing at the beginning of, and periodically, during treatment .both TSH and free T4, in addition to clinical assessment, should be measured at baseline and at follow-up.</p> <p>Further review of the facility's policy and procedures titled Use of Psychotropic Medication, date revised December 19, 2022, indicated, The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as but not limited to .in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the residents comprehensive plan of care.</p> |  |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report an allegation of abuse involving one of three residents reviewed (Resident 55) to California Department of Public Health (CDPH) immediately, but not later than 2 hours after the allegation was made. The facility staff was made aware on April 13, 2025.</p> <p>This failure resulted in the delay of abuse investigation, that placed Resident 55 and other residents at risk when the Certified Occupational Therapy Assistant (COTA) was not suspended immediately in accordance with the facility's policy and procedure.</p> <p>Findings:</p> <p>On May 5, 2025, a review of Resident 55's record indicated Resident 55 was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty in swallowing) following cerebral infarction (also known as ischemic stroke, when the blood flow to the brain is blocked, causing the brain tissue to die), and aphasia (a disorder that affects the ability to speak and understand what others say).</p> <p>A review of the Minimum Data Set (MDS - an assessment tool) dated March 26, 2025, indicated Resident 55 had a Brief Interview for Mental Status (BIMS - an assessment used to screen for cognitive impairment) score of 11 (moderate cognitive impairment).</p> <p>A review of the nurses's progress notes dated April 14, 2025, at 9:30 a.m., indicated the following:</p> <p>.Resident 55 was alert and able to verbalize clearly to the charge nurse that she had a complaint about abuse .;</p> <p>.requested the presence of the Director of Rehab (DOR) and stated stated a male therapist touched her breast, being the second time .She did not report the first incident due to recent illness and weakness . happened a few weeks ago; and able to name such person and identify him .current incident occurred 4/13 in therapy room during therapy session .</p> <p>On May 6, 2025, at 3:44 p.m., the COTA was interviewed. The COTA stated on March 13, 2025, Resident 55 was at the therapy gym sitting in her wheelchair approximately at 11:30 a.m., when he greeted and touched her shoulder. He stated Resident 55 grabbed his hand suddenly and said why did you touched my breast. He stated he was surprised when Resident 55 said that to him. The COTA stated a family member (FM) approached him and asked what happened between him and Resident 55. He told the FM that Resident 55 accused him of touching her breast, and it never happened. He stated the FM believed it was not true. The COTA stated he did not notify his Director, or the Registered Nurse Supervisor (RNS) working on April 13, 2025. He stated he should have notified the Administrator.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On May 6, 2025, at 3:23 p.m., the DOR was interviewed. The DOR stated she was not aware of Resident 55's allegation of abuse until April 14, 2025. She stated the COTA should have called her immediately when Resident 55 made the abuse allegation. She stated the COTA should have been suspended immediately and sent home. She was aware any allegation of abuse should be reported to CDPH immediately within two hours.</p> <p>On May 7, 2025, at 2:13 p.m., the Registered Nurse Supervisor (RNS) was interviewed. The RNS stated she was not aware of Resident 55's allegation of abuse. The COTA did not notify her or other staff about Resident 55's allegation of abuse.</p> <p>On May 8, 2025, at 9:22 a.m., the Nurse Educator (NE) was interviewed. The NE stated The COTA should have reported the incident of alleged abuse immediately to the Administrator.</p> <p>On May 8, 2025, at 2:24 p.m., Certified Nursing Assistant (CNA) 2 was interviewed. CNA 2 stated Resident 55 did not talk about her abuse allegation during her shift on April 13, 2025.</p> <p>On May 8, 2025, at 3:20 p.m., the Director of Nursing (DON) and the Administrator were interviewed. The DON stated the COTA should have reported Resident 55's allegation of abuse to him and the Administrator immediately. The DON stated the COTA did not follow the facility's policy of abuse reporting.</p> <p>A review of the facility's policy and procedure titled, Abuse, Neglect and Exploitation, dated September 2, 2022, indicated, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation .the facility will have written procedures that include .Reporting of all alleged violations to the Administrator, state agency .immediately, but not later than 2 hours .</p> |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. On May 5, 2025, at 11:53 a.m., a concurrent observation and interview was conducted with Resident 11. Resident 11 was observed awake, alert, oriented, and able to verbalize her needs. Resident 11 stated she fell at the independent living facility and shattered her bones on her right ankle. Resident showed her right leg, with old incision on both sides of her ankle. Resident 11 was observed with edema (swelling due to an accumulation of fluids in the body tissues) on her right lower leg.</p> <p>On May 6, 2025, at 3:32 p.m., Resident 11 was observed awake, alert, and able to verbalize her needs. She stated she walked today with the two therapists. She stated she felt much better today than yesterday. The edema on her right lower leg was still present. She stated she elevated her right legs on top of the two pillows.</p> <p>A review of Resident 11's record indicated, Resident 11 was admitted to the facility on [DATE], with diagnoses which included trimalleolar fracture (fracture that involves fractures in all three ankle bones: the medial - the inside of the ankle, the lateral - on the outside, and the posterior - the back) of the right ankle, status post fall from home.</p> <p>A review of the Minimum Data Set (MDS - an assessment tool) dated March 24, 2025, indicated resident's Brief Interview for Mental Status (BIMS - a cognitive tool) score of 13 (cognitively intact). Resident 11 needed moderate assistance with her activity of daily living (ADL).</p> <p>A review of the progress notes indicated the following:</p> <p>a. April 14, 2025, Resident 11 had Open Reduction Internal Fixation (ORIF - a surgical procedure used to repair fractures) of the right ankle.</p> <p>b. April 15, 2025, under education section, elevate extremity in attempt to improve edema .</p> <p>On May 8, 2025, at 10:38 a.m., Resident 11 was observed sitting upright in her bed, awake, alert, and able to verbalize her needs. Resident 11 was observed rubbing her right and left leg. The right leg edema was still present.</p> <p>The Quality Assurance (QA) nurse had entered Resident 11's room.</p> <p>A concurrent observation and interview was conducted with the QA nurse. The QA nurse acknowledged Resident 11's right leg edema, with skin discoloration around the ankle.</p> <p>On May 8, 2025, at 2:15 p.m., a concurrent interview and record review was conducted with the Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 11 has right leg edema. LVN 1 was not able to find a care plan for resident's right leg edema. She stated the licensed nurse who observed and assessed Resident 11's right leg edema should have initiated the care plan.</p> <p>On May 8, 2025, at 2:20 p.m., the QA nurse was interviewed. The QA nurse acknowledged Resident 11 had edema on her right leg. The QA nurse stated there was no care plan initiated for Resident 11, and the licensed staff should have initiated the care plan.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A review of the facility's policy and procedure titled Comprehensive Care Plan, dated December 19, 2022, indicated, .facility to develop and implement a comprehensive person-centered care plan for each resident . includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .</p> <p>Based on observation, interview, and record review, the facility failed to ensure the comprehensive care plans were developed and implemented when:</p> <p>1. For Resident 10, the care plan for the use of Effexor (brand name for venlafaxine, an antidepressant medication used for depression, anxiety, and panic disorder) XR (extended release, designed to release medicine slowly into the body over a prolonged period) was not initiated and developed.</p> <p>This failure had the potential to increase Resident 10's risk of not being provided appropriate, consistent, and individualized care.</p> <p>2. For Resident 11, the care plan for the right leg edema was not initiated and developed.</p> <p>This failure had the potential not to be able to meet the person-centered goals and objectives for Resident 11's right leg edema and delay the necessary care and services for her recovery and discharge.</p> <p>Findings:</p> <p>1. A review of Resident 10's admission record indicated he was admitted to the facility on [DATE], with diagnoses which included depression.</p> <p>A review of Resident 10's medical record indicated he had been receiving Effexor (brand name for venlafaxine) XR (extended release, designed to release medicine slowly into to body over a prolonged period) in various doses since August 2024.</p> <p>A review of Resident 10's current Order Summary Report, dated May 9, 2025, indicated the following provider orders:</p> <ul style="list-style-type: none"> <li>- Effexor XR (venlafaxine) 75 mg (milligram, unit of measurement) one time a day for verbalization of feeling sad related to depression, dated May 1, 2025; and</li> <li>- Monitor for side effects related to use of psychotropic medications. My initials indicate absence of signs and symptoms of side effects, dated July 18, 2024.</li> </ul> <p>A review of Resident 10's clinical record indicated no care plan was developed and implemented for Resident 10's depression and use of Effexor XR.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a concurrent interview and record review on May 8, 2025, at 11:55 a.m., with the Quality Assurance (QA) nurse, Resident 10's medical record was reviewed. When asked how nursing staff would know what side effects to monitor during the use of Effexor XR, the QA nurse stated side effects would have been listed on the resident's care plan. The QA nurse confirmed there was no care plan developed for depression and use of Effexor XR. The QA nurse acknowledged a care plan should have been developed. The QA nurse stated a care plan was needed for nursing staff to know how to manage side effects and evaluate the effectiveness of the medication.</p> <p>During an interview on May 8, 2025, at 4:19 p.m., with the Director of Nursing (DON), the DON acknowledged Resident 10 did not have a care plan developed for depression and use of Effexor XR. The DON stated the expectation was for nursing staff to have developed a care plan to ensure there was a guide to care for the resident.</p> <p>A review of the facility's policy and procedures titled Comprehensive Care Plans, date revised December 19, 2022, indicated, The comprehensive care plan will be developed with 7 days after the completion of the comprehensive MDS [The Minimum Data Set, assessment tool used to assess the needs and characteristics of residents] assessment.</p> |  |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. On May 7, 2025, Resident 187's record was reviewed. Resident 187 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - a lung disease causing restricted airflow and breathing problems).</p> <p>A review of the physician's progress notes dated March 25, 2025, at 7:02 a.m., indicated, .breath sounds dull at bases with intermittent congestion .Resident had chronic respiratory failure and emphysema (long term lung condition that causes shortness of breath) .</p> <p>There was no respiratory rate documented on March 23, 24, and 25, 2025.</p> <p>Resident 187's care plan, initiated on August 26, 2024, indicated, .The Resident has potential altered respiratory status/difficulty breathing r/t (related to) COPD, Emphysema .Interventions . Monitor/document/report abnormal breathing patterns to MD (physician): increased rate, decreased rate .</p> <p>A review of Resident 187's weights and vitals summary, indicated nursing staff did not take and document the respiratory rate as indicated in the resident's care plan on March 23, 24, and 25, 2025.</p> <p>On May 8, 2025, at 10:21 a.m., Certified Nursing Assistant (CNA) 3 was interviewed. She stated resident's vital signs (V/S - measurement of a person's basic functions that provide insights into how the body is working and can indicate potential health problems or emergencies) were taken at least once a shift and as needed. She stated vital signs included temperature, blood pressure, heart rate, oxygen saturation (amount of oxygen in blood) and respiratory rate. CNA 3 stated V/S should be documented in the electronic medical record (EMR).</p> <p>On May 8, 2025, at 10:31 a.m., in a concurrent interview and record review with LVN 3, she stated V/S should be done at least once a shift if resident was stable. She stated V/S included temperature, pulse rate, respiratory rate, oxygen saturation, and blood pressure. She stated there was no need for a physician's order to do V/S.</p> <p>On May 8, 2025, at 10:45 a.m., a concurrent interview and record review with the Director for Staff Development (DSD) was conducted. The DSD stated Resident 187 was admitted with diagnoses which included COPD and emphysema. The DSD stated that residents with a diagnosis of COPD and emphysema should be monitored for respiratory rate and oxygen saturation. She stated V/S should be checked and documented at least once a shift. She stated the respiratory rate should have been taken and documented on March 23, 24, and 25, 2025.</p> <p>On May 8, 2025, at 2:45 p.m., the Director of Nursing (DON) was interviewed. The DON stated as a standard of practice, the CNAs take the V/S and document in EMR. He stated oxygen saturation and respiratory rate should be taken for residents with lung disease.</p> <p>A review of the facility policy and procedure titled, Vital Signs, revised December 19, 2022, indicated, .Vital signs are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain .</p> <p>(continued on next page)</p> |  |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
|---|---|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Based on interview and record review, the facility failed to ensure five of 28 sampled residents (Residents 7, 10, 47, 182, and 187) received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, when:</p> <ol style="list-style-type: none"> <li>For Residents 7, 10, 47, and 182, the nursing staff did not rotate subcutaneous (under the skin) insulin injection sites in accordance with the facility policy and procedures (P&amp;P). Additionally, for Residents 7 and 47, the nursing staff did not notify the doctor when blood sugar (BS) results were below 70 in accordance with the doctor's insulin (medication to treat diabetes) sliding scale (a chart with insulin doses to maintain blood sugar levels) order; and</li> <li>For Resident 187, the nursing staff did not monitor and document the respiratory rate as indicated in the resident's care plan on March 23, 24, and 25, 2025.</li> </ol> <p>These failures had the potential to compromise the resident's health and well-being.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During an interview on May 8, 2025 at 4:40 p.m., with the Director of Nursing (DON), regarding when a provider's insulin sliding scale orders indicated to call the doctor for BS less than 70, the DON stated the expectation was for nursing staff to have called the doctor and documented the communication with the doctor in the residents' medical record. Additionally, the DON stated the expectation was for nursing staff to have rotated the subcutaneous insulin injection site location for every dose of insulin administration.</li> </ol> <p>During an interview on May 9, 2025 at 12:06 p.m. with Licensed Vocational Nurse (LVN) 2. LVN 2 stated nursing staff should have followed the provider's insulin sliding scale order and notified the doctor when the residents' blood sugar levels were below 70, documented the communication with the doctor in the residents' medical record, and documented the BS result on the residents' medication administration record (MAR). Additionally, LVN 2 stated nurses were expected to rotate the subcutaneous insulin injection site location for every dose of insulin administration.</p> <p>1a. A review of Resident 7's admission record indicated she was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included diabetes.</p> <p>A review of Resident 7's medical record indicated she had been receiving a prefilled insulin glargine (brand name: Lantus SoloStar pen, medication for diabetes) 100 units/milliliter (ml, unit of measurement) pen and Humalog (brand name for insulin lispro, medication for diabetes) 100 units/ml insulin sliding scale since December 2024.</p> <p>A review of Resident 7's current Order Summary Report, dated May 8, 2025, indicated the following provider orders:</p> <ul style="list-style-type: none"> <li>- April 28, 2025, Lantus SoloStar Pen-Injector 100 units/ml (insulin glargine), Inject 5 units subcutaneously two times a day related to diabetes; and</li> </ul> <p>(continued on next page)</p> |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>- February 17, 2025, Humalog Injection Solution 100 units/ml (Insulin Lispro), Inject as per sliding scale if (BS) 0 - 150 = 0 unit (no insulin); 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; BS &amp;gt; (greater than) 350 mg (milligram, unit of measurement) /dl (deciliter, unit of measurement) give 10 units &amp; notify MD (medical doctor), also if BS &amp;lt; (less than) 70 mg/dl, subcutaneously before meals and at bedtime related to diabetes, check BS (blood sugar) before insulin administration, document, and rotate site.</p> <p>A review of Resident 7's blood sugar records indicated her BS was below 70 on the following dates and times:</p> <ul style="list-style-type: none"> <li>- January 29, 2025, at 13:15 (1:15 p.m.), BS = 68 mg/dl;</li> <li>- February 3, 2025, at 07:22 (7:22 a.m.), BS = 53 mg/dl;</li> <li>- February 4, 2025, at 20:51 (10:51 p.m.), BS = 54 mg/dl;</li> <li>- February 7, 2025, at 06:52 (6:52 a.m.), BS = 65 mg/dl;</li> <li>- February 23, 2025, at 17:12 (5:12 p.m.), BS = 35 mg/dl; and</li> <li>- March 8, 2025, at 17:20 (5:20 p.m.), BS = 49 mg/dl.</li> </ul> <p>A review of Resident 7's MARs dated January, February, and March 2025, indicated nursing staff documented Lantus SoloStar Pen-Injector and Humalog Injection Solution insulin sliding scale were not administered to Resident 7 on the above dates and times.</p> <p>A review of Resident 7's Orders - Administration Notes, dated February 3, 2025 at 07:22 (7:22 a.m.), February 4, 2025, at 20:51 (10:51 p.m.), February 7, 2025 at 06:52 (6:52 a.m.), February 23, 2025, at 17:12 (5:12 p.m.), and March 8, 2025, at 17:20 (5:20 p.m.), indicated there was no evidence of nursing documentation that the doctor was notified when Resident 7's blood sugar levels were below 70, as prescribed on the provider's order for Humalog Injection Solution 100 units/ml insulin sliding scale dated February 17, 2025. Additionally, there was no evidence of nursing documentation that the doctor was notified when Resident 7's blood sugar levels was below 70 on January 29, 2025 at 13:15 (1:15 p.m.) when BS was 68 mg/dl.</p> <p>Further review of Resident 7's MARs dated January 1, 2025 to May 8, 2025, indicated nursing staff administered Lantus SoloStar Pen-Injector and Humalog Injection Solution insulins by subcutaneous injections without rotating the injection site location for each dose in accordance with the facility's P&amp;P on the following dates, times, and location of administration:</p> <p>For Lantus SoloStar Pen-Injector 100 units/ml insulin:</p> <p>Administered date, Time, and Location of administration</p> <ul style="list-style-type: none"> <li>- January 1, 2025, at 10:29 a.m., Arm - left;</li> <li>- January 1, 2025, at 17:26 (5:26 p.m.), Arm - left;</li> </ul> <p>(continued on next page)</p> |  |  |

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|---|---|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- January 3, 2025, at 17:50 (5:50 p.m.), Arm - left;</li> <li>- January 4, 2025, at 10:28 a.m., Arm - left;</li> <li>- January 4, 2025, at 21:15 (9:19 p.m.), Arm - left;</li> <li>- January 5, 2025, at 17:10 (5:10 p.m.), Arm - left;</li> <li>- January 6, 2025, at 13:28 (1:28 p.m.), Arm - left;</li> <li>- January 11, 2025, at 13:57 (1:57 p.m.), Arm - right;</li> <li>- January 11, 2025, at 17:52 (5:52 p.m.), Arm - right;</li> <li>- January 12, 2025, at 08:32 (8:32 a.m.), Arm - left;</li> <li>- January 12, 2025, at 17:32 (5:32 p.m.), Arm - left;</li> <li>- January 15, 2025, at 09:29 (9:29 a.m.), Arm - left;</li> <li>- January 15, 2025, at 18:42 (6:42 p.m.), Arm - left;</li> <li>- January 16, 2025, at 10:49 a.m., Arm - right;</li> <li>- January 16, 2025, at 17:34 (5:34 p.m.), Arm - right;</li> <li>- January 22, 2025, at 16:48 (4:48 p.m.), Arm - left;</li> <li>- January 23, 2025, at 10:00 a.m., Arm - left;</li> <li>- January 23, 2025, at 16:31 (4:31 p.m.), Arm - left;</li> <li>- January 24, 2025, at 17:34 (5:34 p.m.), Arm - left;</li> <li>- January 25, 2025, at 09:41 (9:41 a.m.), Arm - left;</li> <li>- February 1, 2025, at 09:02 (9:02 a.m.), Arm - right;</li> <li>- February 1, 2025, at 18:50 (6:50 p.m.) Arm - right;</li> <li>- February 2, 2025, at 10:02 a.m., Arm - right;</li> <li>- February 7, 2025, at 08:03 (8:03 a.m.), Arm - right;</li> <li>- February 8, 2025, at 10:01 a.m., Arm - right;</li> <li>- February 18, 2025, at 12:46 p.m., Arm - right;</li> </ul> <p>(continued on next page)</p> |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>4070 Jurupa Avenue<br>Riverside, CA 92506 |  |

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|---|---|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- February 18, 2025, at 17:38 (5:38 p.m.), Arm - right;</li> <li>- March 1, 2025, at 10:38 a.m., Arm - right;</li> <li>- March 1, 2025, at 17:14 (5:14 p.m.), Arm - right;</li> <li>- March 2, 2025, at 09:01 (9:01 a.m.), Arm - right;</li> <li>- March 2, 2025, at 17:22 (5:22 p.m.), Arm - right;</li> <li>- March 3, 2025, at 08:51 (8:51 a.m.), Arm - right;</li> <li>- March 4, 2025, at 08:52 (8:52 a.m.), Arm - right;</li> <li>- March 8, 2025, at 08:31 (8:31 a.m.), Arm - right;</li> <li>- March 9, 2025, at 10:15 a.m., Arm - right;</li> <li>- March 14, 2025, at 08:55 (8:55 a.m.), Arm - left;</li> <li>- March 14, 2025, at 17:19 (5:19 p.m.), Arm - left;</li> <li>- March 20, 2025, at 08:59 (8:59 a.m.), Arm - right;</li> <li>- March 20, 2025, at 17:21 (5:21 p.m.), Arm - right;</li> <li>- March 25, 2025, at 10:29 a.m., Arm - right;</li> <li>- March 25, 2025, at 17:29 (5:29 p.m.), Arm - right;</li> <li>- April 1, 2025, at 18:14 (6:14 p.m.), Arm - left;</li> <li>- April 2, 2025, at 09:50 (9:50 a.m.), Arm - left;</li> <li>- April 12, 2025, at 08:56 (8:56 a.m.), Arm - right;</li> <li>- April 12, 2025, at 17:48 (5:48 p.m.), Arm - right;</li> <li>- April 13, 2025, at 09:12 (9:12 a.m.), Arm - right;</li> <li>- April 13, 2025, at 18:21 (6:21 p.m.), Arm - right;</li> <li>- April 14, 2025, at 08:32 (8:32 a.m.), Arm - left;</li> <li>- April 14, 2025, at 17:47 (5:47 p.m.), Arm - left;</li> <li>- April 19, 2025, at 16:54 (4:54 p.m.), Arm - left;</li> </ul> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- April 20, 2025, at 12:02 p.m., Arm - left;</li> <li>- April 24, 2025, at 18:00 (6 p.m.), Arm - right;</li> <li>- April 25, 2025, at 09:10 (9:10 a.m.), Arm - right;</li> <li>- May 3, 2025, at 18:01 (6:01 p.m.), Abdomen - LUQ; and</li> <li>- May 4, 2025, at 18:16 (6:16 p.m.), Abdomen - LUQ.</li> </ul> <p>For Humalog Injection Solution 100 units/ml insulin:</p> <p>Administered date, Time, and Location of administration</p> <ul style="list-style-type: none"> <li>- January 7, 2025, at 12:50 p.m., Arm - left;</li> <li>- January 7, 2025, at 21:22 (9:22 p.m.), Arm - left;</li> <li>- January 8, 2025, at 06:30 (6:30 a.m.), Arm - left;</li> <li>- January 8, 2025, at 12:33 p.m., Arm - right;</li> <li>- January 8, 2025, at 16:37 (4:37 p.m.), Arm - right;</li> <li>- January 8, 2025, at 21:52 (9:52 p.m.), Arm - right;</li> <li>- January 10, 2025, at 06:38 (6:38 a.m.), Arm - left;</li> <li>- January 10, 2025, at 12:46 p.m., Arm - left;</li> <li>- January 11, 2025, at 13:57 (1:57 p.m.), Arm - right;</li> <li>- January 11, 2025, at 17:47 (5:47 p.m.), Arm - right;</li> <li>- January 11, 2025, at 20:45 (8:45 p.m.), Arm - left;</li> <li>- January 12, 2025, at 07:00 (7:00 a.m.), Arm - left;</li> <li>- January 13, 2025, at 17:20 (5:20 p.m.), Arm - left;</li> <li>- January 14, 2025, at 06:42 (6:42 a.m.), Arm - left;</li> <li>- January 14, 2025, at 18:36 (6:36 p.m.), Arm - Upper arm (rear) (left);</li> <li>- January 14, 2025, at 22:09 (10:09 p.m.), Arm - Upper arm (rear) (left);</li> <li>- January 15, 2025, at 18:37 (6:37 p.m.), Arm - left;</li> </ul> <p>(continued on next page)</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- January 16, 2025, at 06:38 (6:38 a.m.), Arm - left;</li> <li>- January 19, 2025, at 13:03 (1:03 p.m.), Arm - right;</li> <li>- January 20, 2025, at 06:36 (6:36 a.m.), Arm - right;</li> <li>- January 22, 2025, at 12:25 p.m., Arm - left;</li> <li>- January 22, 2025, at 16:45 (4:45 p.m.), Arm - left;</li> <li>- January 23, 2025, at 21:57 (9:57 p.m.), Arm - left;</li> <li>- January 24, 2025, at 06:36 (6:36 a.m.), Arm - left;</li> <li>- January 24, 2025, at 12:53 p.m., Arm - left;</li> <li>- January 24, 2025, at 16:20 (4:20 p.m.), Arm - left;</li> <li>- January 30, 2025, at 11:59 a.m., Arm - right;</li> <li>- January 30, 2025, at 17:24 (5:24 p.m.), Arm - right;</li> <li>- January 31, 2025, at 12:31 p.m., Arm - right;</li> <li>- January 31, 2025, at 21:22 (9:22 p.m.), Arm - right;</li> <li>- February 1, 2025, at 18:45 (6:25 p.m.), Arm - left;</li> <li>- February 1, 2025, at 22:45 (10:45 p.m.), Arm - left;</li> <li>- February 4, 2025, at 06:29 (6:29 a.m.), Arm - left;</li> <li>- February 4, 2025, at 13:59 (1:59 p.m.), Arm - left;</li> <li>- February 4, 2025, at 17:36 (5:36 p.m.), Arm - left;</li> <li>- February 5, 2025, at 06:40 (6:40 a.m.), Arm - left;</li> <li>- February 6, 2025, at 06:37 (6:37 a.m.), Arm - left;</li> <li>- February 6, 2025, at 17:29 (5:29 p.m.), Arm - left;</li> <li>- February 19, 2025, at 17:59 (5:59 p.m.), Arm - Upper arm (rear) (left);</li> <li>- February 19, 2025, at 21:48 (9:48 p.m.), Arm - Upper arm (rear) (left);</li> <li>- February 20, 2025, at 17:28 (5:28 p.m.), Arm - Upper arm (rear) (left);</li> </ul> <p>(continued on next page)</p> |

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|---|---|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- February 20, 2025, at 22:27 (5:27 p.m.), Arm - Upper arm (rear) (left);</li> <li>- March 1, 2025, at 06:39 (6:39 a.m.), Arm - left;</li> <li>- March 1, 2025, at 17:12 (5:12 p.m.), Arm - left;</li> <li>- March 2, 2025, at 06:39 (6:39 a.m.), Arm - left;</li> <li>- March 2, 2025, at 17:22 (5:22 p.m.), Arm - left;</li> <li>- March 6, 2025, at 19:20 (7:20 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 6, 2025, at 22:03 (10:03 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 7, 2025, at 17:21 (5:21 p.m.), Arm - left;</li> <li>- March 8, 2025, at 06:30 (6:30 a.m.), Arm - left;</li> <li>- March 10, 2025, at 06:59 (6:59 a.m.), Arm - left;</li> <li>- March 10, 2025, at 12:17 p.m., Arm - left;</li> <li>- March 11, 2025, at 06:45 (6:45 a.m.), Arm - left;</li> <li>- March 11, 2025, at 12:18 p.m., Arm - left;</li> <li>- March 12, 2025, at 19:38 (7:38 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 12, 2025, at 21:01 (9:01 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 13, 2025, at 06:39 (6:39 a.m.), Arm - left;</li> <li>- March 13, 2025, at 17:00 (5 p.m.), Arm - left;</li> <li>- March 14, 2025, at 06:25 (6:25 a.m.), Arm - left;</li> <li>- March 14, 2025, at 17:19 (5:19 p.m.), Arm - right;</li> <li>- March 14, 2025, at 22:00 (10 p.m.), Arm - left;</li> <li>- March 15, 2025, at 06:42 (6:42 a.m.), Arm - left;</li> <li>- March 15, 2025, at 18:03 (6:03 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 15, 2025, at 20:50 (8:50 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 16, 2025, at 17:36 (5:36 p.m.), Arm - Upper arm (rear) (right);</li> </ul> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
|---|---|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- March 16, 2025, at 20:57 (8:57 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 19, 2025, at 06:46 (6:46 a.m.), Arm - left;</li> <li>- March 19, 2025, at 12:56 p.m., Arm - left;</li> <li>- March 20, 2025, at 06:39 (6:39 a.m.), Arm - left;</li> <li>- March 20, 2025, at 17:20 (5:20 p.m.), Arm - left;</li> <li>- March 23, 2025, at 18:37 (6:37 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 23, 2025, at 20:58 (8:58 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 25, 2025, at 17:28 (5:28 p.m.), Arm - left;</li> <li>- March 25, 2025, at 21:22 (9:22 p.m.), Arm - left;</li> <li>- March 26, 2025, at 07:03 (7:03 a.m.), Arm - left;</li> <li>- March 26, 2025, at 17:33 (5:33 p.m.), Arm - left;</li> <li>- March 26, 2025, at 21:36 (9:36 p.m.), Arm - left;</li> <li>- March 27, 2025, at 07:48 (7:48 a.m.), Arm - left;</li> <li>- April 1, 2025, at 06:53 (6:53 a.m.), Arm - left;</li> <li>- April 1, 2025, at 12:34 p.m., Arm - left;</li> <li>- April 1, 2025, at 21:42 (9:42 p.m.), Arm - left;</li> <li>- April 9, 2025, at 17:43 (5:43 p.m.), Arm - Upper arm (rear) (right);</li> <li>- April 9, 2025, at 21:57 (9:57 p.m.), Arm - Upper arm (rear) (right);</li> <li>- April 11, 2025, at 18:08 (6:08 p.m.), Arm - Upper arm (rear) (right);</li> <li>- April 11, 2025, at 21:50 (9:50 p.m.), Arm - Upper arm (rear) (right);</li> <li>- April 12, 2025, at 07:03 (7:03 a.m.), Arm - left;</li> <li>- April 12, 2025, at 17:05 (5: 05 p.m.), Arm - left;</li> <li>- April 12, 2025, at 22:04 (10:04 p.m.), Arm - left;</li> <li>- April 13, 2025, at 06:02 (6:02 a.m.), Arm - left;</li> </ul> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
|---|---|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- April 13, 2025, at 17:26 (5: 26 p.m.), Arm - left;</li> <li>- April 13, 2025, at 22:00 (10 p.m.), Arm - left;</li> <li>- April 14, 2025, at 06:56 (6:56 a.m.), Arm - left;</li> <li>- April 18, 2025, at 12:41 p.m., Arm - right;</li> <li>- April 18, 2025, at 21:00 (9 p.m.), Arm - right;</li> <li>- April 19, 2025, at 12:50 p.m., Arm - right;</li> <li>- April 20, 2025, at 12 p.m., Arm - right;</li> <li>- April 24, 2025, at 06:34 (6:34 p.m.), Arm - left;</li> <li>- April 24, 2025, at 17:23 (5:23 p.m.), Arm - left;</li> <li>- April 24, 2025, at 21:20 (9:20 p.m.), Arm - left;</li> <li>- April 26, 2025, at 17:20 (5:20 p.m.), Arm - Upper arm (rear) (right);</li> <li>- April 26, 2025, at 21:12 (9:12 p.m.), Arm - Upper arm (rear) (right);</li> <li>- April 27, 2025, at 18:11 (6:11 p.m.), Arm - Upper arm (rear) (left);</li> <li>- April 27, 2025, at 21:39 (9:39 p.m.), Arm - Upper arm (rear) (left);</li> <li>- April 30, 2025, at 06:28 (6:28 a.m.), Arm - left;</li> <li>- April 30, 2025, at 17:27 (5:27 p.m.), Arm - left;</li> <li>- May, 7, 2025, at 12:48 p.m., Arm - left; and</li> <li>- May, 7, 2025, at 17:30 (5:30 p.m.), Arm - left.</li> </ul> <p>During a follow-up concurrent interview and record review on May 9, 2025 at 2:10 p.m., with the DON, Resident 7's medical record, including the MARs dated January 2025 to May 2025, and the Orders - Administration Notes listed above, were reviewed. The DON acknowledged there was no evidence in Resident 7's medical record of documentation by nursing staff that the doctor was notified when BS was less than 70 on the above dates and times and stated there should have been documentation. Additionally, the DON acknowledged nursing staff did not rotate insulin injection site locations on the above dates and times and stated the injection site locations should have been rotated for each dose of insulin.</p> <p>1b. A review of Resident 47's admission record indicated she was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included diabetes.</p> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A review of Resident 47's medical record indicated she had been receiving a prefilled insulin glargine (brand name: Basaglar KwikPen, medication for diabetes) 100 units/ml pen since November 2024, and Humalog Solution (Insulin Lispro), insulin sliding scale since February 2025.</p> <p>A review of Resident 47's current Order Summary Report, dated May 9, 2025, indicated the following provider orders:</p> <ul style="list-style-type: none"> <li>- March 19, 2025, Basaglar KwikPen 100 units/ml (insulin glargine), Inject 12 units subcutaneously in the afternoon one time a day related to diabetes, hold if BS &lt; 70 mg/dl, patient refuses to eat her meals or NPO (nothing by mouth), document and rotate [injection] site;</li> <li>- March 19, 2025, Basaglar KwikPen 100 units/ml (insulin glargine), Inject 15 units subcutaneously one time a day related to diabetes, hold if BS &lt; 70 mg/dl, patient refuses to eat her meals or NPO (nothing by mouth), document and rotate [injection] site; and</li> <li>- March 19, 2025, Humalog Solution (Insulin Lispro), Inject as per sliding scale if [BS] 121 - 150 = 2 units; 151 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12 units; 401+ &gt; 400 or &lt; 70 , Call MD. subcutaneously before meals related to diabetes, may hold 0730 (7:30 a.m.) and 1100 (11 a.m.) on HD (hemodialysis) days.</li> </ul> <p>A review of Resident 47's blood sugar records indicated her BS was below 70 on the following dates and times:</p> <ul style="list-style-type: none"> <li>- March 29, 2025, at 05:59 (5:59 a.m.), BS = 64 mg/dl;</li> <li>- March 31, 2025, at 06:10 (6:10 a.m.), BS = 65 mg/dl;</li> <li>- April 19, 2025, at 04:50 (4:50 a.m.), BS = 58.0 mg/dl; and</li> <li>- May 7, 2025, at 05:26 (5:26 a.m.), BS = 53.0 mg/dl.</li> </ul> <p>A review of Resident 47's MARs dated March, April, and May 2025 indicated nursing staff documented Basaglar KwikPen and Humalog Solution insulin sliding scale were not administered to Resident 47 on the above dates and times.</p> <p>A review of Resident 47's Orders - Administration Note, dated March 29, 2025, at 05:59 (5:59 a.m.), March 31, 2025, at 06:10 (6:10 a.m.), April 19, 2025, at 04:50 (4:50 a.m.), and May 7, 2025, at 05:26 (5:26 a.m.), indicated there was no evidence of nursing documentation that the doctor was notified when Resident 47's blood sugar levels were below 70, as prescribed on the provider's order for Humalog Solution (Insulin Lispro) insulin sliding scale dated March 19, 2025.</p> <p>Further review of Resident 47's MARs dated from March 1, 2025 to May 8, 2025 indicated nursing staff administered Basaglar KwikPen and Humalog Solution insulin sliding scale by subcutaneous injections without rotating the injection site location for each dose according to the facility's P&amp;P on the following dates, times, and location of administration:</p> <p>For Basaglar KwikPen 100 units/ml (insulin glargine) insulin:</p> <p>(continued on next page)</p> |  |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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.

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|---|--|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Administered date, Time, and Location of administration</p> <ul style="list-style-type: none"> <li>- March 3, 2025, at 05:24 (5:24 a.m.), Arm - left;</li> <li>- March 4, 2025, at 05:17 (5:17 a.m.), Arm - left;</li> <li>- March 6, 2025, at 06:38 (6:38 a.m.), Arm - Upper arm (rear) (left);</li> <li>- March 7, 2025, at 06:30 (6:30 a.m.), Arm - Upper arm (rear) (left);</li> <li>- March 8, 2025, at 05:21 (5:21 a.m.), Arm - left;</li> <li>- March 9, 2025, at 06:58 ( 6:58 a.m.), Arm - left;</li> <li>- March 10, 2025, at 05:22 (5:22 a.m.), Arm - left;</li> <li>- March 24, 2025, at 16:52 (4:52 p.m.), Arm - Upper arm (rear) (left);</li> <li>- March 25, 2025, at 06:20 (6:20 a.m.), Arm - Upper arm (rear) (left);</li> <li>- April 12, 2025, at 17:29 (5:29 p.m.), Arm - Upper arm (rear) (left);</li> <li>- April 13, 2025, at 05:46 (5:46 a.m.), Arm - Upper arm (rear) (left);</li> <li>- April 19, 2025, at 17:13 (5:13 p.m.), Arm - left;</li> <li>- April 20, 2025, at 05:28 (5:28 a.m.), Arm - left;</li> <li>- May 3, 2025, at 16:34 (4:34 p.m.), Arm - left;</li> <li>- May 4, 2025, at 05:53 (5:53 a.m.), Arm - left;</li> <li>- May 6, 2025, at 17:21 (5:21 p.m.), Arm - right; and</li> <li>- May 7, 2025, at 17:03 (5:03 p.m.), Arm - right.</li> </ul> <p>For Humalog Solution insulin:</p> <p>Administered date, Time, and Location of administration</p> <ul style="list-style-type: none"> <li>- March 2, 2025, at 11:54 a.m., Arm - left;</li> <li>- March 2, 2025, at 17:32 (5:32 p.m.), Arm - left;</li> <li>- March 3, 2025, at 05:25 (5:25 a.m.), Arm - left;</li> <li>- March 3, 2025, at 11:13 a.m., Arm - left;</li> </ul> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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.

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|---|--|
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <ul style="list-style-type: none"> <li>- March 4, 2025, at 05:18 (5:18 a.m.), Arm - left;</li> <li>- March 7, 2025, at 16:47 (4:47 p.m.), Arm - left;</li> <li>- March 8, 2025, at 05:16 (5:16 a.m.), Arm - left;</li> <li>- March 8, 2025, at 16:50 (4:50 p.m.), Arm - left;</li> <li>- March 9, 2025, at 05:13 (5:13 a.m.), Arm - left;</li> <li>- March 9, 2025, at 11:08 a.m., Arm - left;</li> <li>- March 10, 2025, at 05:13 (5:13 a.m.), Arm - left;</li> <li>- March 10, 2025, at 12:16 p.m., Arm - left;</li> <li>- March 25, 2025, at 16:56 (4:56 p.m.), Arm - left;</li> <li>- March 26, 2025, at 12:59 p.m., Arm - left;</li> <li>- March 29, 2025, at 16:25 (4:25 p.m.), Arm - left;</li> <li>- March 30, 2025, at 11:06 a.m., Arm - left;</li> <li>- March 31, 2025, at 11:25 a.m., Arm - left;</li> <li>- March 31, 2025, at 17:15 (5:15 p.m.), Arm - left;</li> <li>- April 1, 2025, at 17:17 (5:17 p.m.), Arm - left;</li> <li>- April 2, 2025, at 11:52 a.m., Arm - left;</li> <li>- April 4, 2025, at 11:24 a.m., Arm - left;</li> <li>- April 4, 2025, at 17:06 (5:06 p.m.), Arm - left;</li> <li>- April 9, 2025, at 11:32 a.m., Arm - left;</li> <li>- April 9, 2025, at 17:25 (5:25 p.m.), Arm - left;</li> <li>- April 13, 2025, at 11:43 a.m., Arm - left;</li> <li>- April 13, 2025, at 17:11 (5:11 p.m.), Arm - left;</li> <li>- April 14, 2025, at 12:07 p.m., Arm - left;</li> <li>- April 15, 2025, at 16:13 (4:13 p.m.), Arm - left;</li> </ul> <p>(continued on next page)</p> |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <ul style="list-style-type: none"> <li>- April 16, 2025, at 12:05 p.m., Arm - left;</li> <li>- April 19, 2025, at 17:14 (5:14 p.m.), Arm - left;</li> <li>- April 20, 2025, at 12:01 p.m., Arm - left;</li> <li>- April 21, 2025, at 05:35 (5:35 a.m.), Arm - left;</li> <li>- April 21, 2025, at 13:12 (1:12 p.m.), Arm - left;</li> <li>- April 24, 2025, at 17:32 (5:32 p.m.), Arm - left;</li> <li>- April 25, 2025, at 11:14 a.m., Arm - left;</li> <li>- April 30, 2025, at 12:39 p.m., Arm - left;</li> <li>- April 30, 2025, at 17:20 (5:20 p.m.), Arm - left;</li> <li>- May 1, 2025, at 17:15 (5:15 p.m.), Arm - left;</li> <li>- May 2, 2025, at 12:09 p.m., Arm - left;</li> <li>- May 3, 2025, at 16:33 (4:33 p.m.), Arm - left;</li> <li>- May 4, 2025, at 11:28 a.m., Arm - left;</li> <li>- May 5, 2025, at 12:06 p.m., Arm - left;</li> <li>- May 5, 2025, at 16:25 (4:25 p.m.), Arm - left;</li> <li>- May 6, 2025, at 17:22 (5:22 p.m.), Arm - left;</li> <li>- May 7, 2025, at 11:24 a.m., Arm - left;</li> <li>- May 7, 2025, at 17:10 (5:10 p.m.), Arm - right; and</li> <li>- May 8, 2025, at 12:29 p.m., Arm - right.</li> </ul> <p>During a follow-up concurrent interview and record review on May 9, 2025, at 2:20 p.m., with the DON, Resident 47's medical record, including the MARs dated March, April, and May 2025, and the Orders - Administration Notes listed above, were reviewed. The DON acknowledged there was no evidence in Resident 47's medical record of documentation by nursing staff that the doctor was notified when BS was less than 70 on the above dates and times and stated there should have been documentation. Additionally, the DON acknowledged nursing staff did not rotate insulin injection site locations on the above dates and times and stated the injection site locations should have been rotated for each dose of insulin.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>1c. A review of Resident 10's admission record indicated he was admitted to the facility on [DATE], with diagnoses including diabetes.</p> <p>A review of Resident 10's MARs dated from March 1, 2025 to May 8, 2025, indicated the following provider orders:</p> <ul style="list-style-type: none"> <li>- November 10, 2024 to April 19, 2025, Humulin 70/30 (A combination of both short and intermediate-acting insulins, medication for diabetes) KwikPen Pen-injector 100 unit/ml, Inject 8 unit subcutaneously two times a day related to diabetes before breakfast and dinner; and</li> <li>- April 20, 2025, Novolin 70/30 (A combination of both short and intermediate-acting insulins, medication for diabetes) FlexPen Pen-injector 100 unit/ml, Inject 4 unit subcutaneously two times a day related to diabetes.</li> </ul> <p>Further review of Resident 10's MARs dated from March 1, 2025 to May 8, 2025 indicated nursing staff administered Humulin 70/30 KwikPen Pen-injector and Novolin 70/30 FlexPen Pen-injector insulin by subcutaneous injections without rotating the injection site location for each dose in accordance with the facility P&amp;P on the following dates, times, and location of administration:</p> <p>For Humulin 70/30 KwikPen Pen-injector 100 unit/ml insulin:</p> <p>Administered date, Time, and Location of administration</p> <ul style="list-style-type: none"> <li>- March 2, 2025, at 17:37 (5:37 p.m.), Arm - right;</li> <li>- March 3, 2025, at 05:31 (5:31 a.m.), Arm - right;</li> <li>- March 7, 2025, at 17:05 (5:05 p.m.), Arm - right;</li> <li>- March 8, 2025, at 05:25 (5:25 a.m.), Arm - right;</li> <li>- March 8, 2025, at 16:57 (4:57 p.m.), Arm - right;</li> <li>- March 9, 2025, at 05:25 (5:25 a.m.), Arm - right;</li> <li>- March 10, 2025, at 16:45 (4:45 p.m.), Arm - Upper arm (rear) (right);</li> <li>- March 11, 2025, at 06:14 (6:14 a.m.), Arm - Upper arm (rear) (right);</li> <li>- March 11, 2025, at 16:12 (4:12 p.m.), Arm - Upper arm (rear) (left);</li> <li>- March 12, 2025, at 06:05 (6:05 a.m.), Arm - Upper arm (rear) (right)</li> <li>- March 13, 2025, at 17:16 (5:16 p.m.), Arm - right;</li> <li>- March 14, 2025, at 05:19 (5:19 p.m.), Arm - right;</li> <li>- March 16, 2025, at 16:47 (4:47 p.m.), Arm - Upper arm (rear) (right);</li> </ul> <p>(continued on next page)</p> |  |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>- March 17, 2025, at 06:10 (6:10 a.m.), Arm - Upper arm (rear) (right);</p> <p>- March 26, 2025, at 17:39 (5:39 p.m.), Arm - right;</p> <p>- March 27, 2025, at 05:32 (5:32 a.m.), Arm - right;</p> <p>- April 7, 2025, at 17:30 (5:30 p.m.), Arm - right;</p> <p>- April 8, 2025, at 06:31 (6:31 a.m.), Arm - right; and</p> <p>- April 19, 2025, at 17:18 (5:18p.m.), Arm - left.</p> <p>For Novolin 70/30 FlexPen Pen-injector 100 unit/ml insulin:</p> <p>Administered date, Time, and Location of administration</p> <p>- April 20, 2025, at 05:31 Arm - left;</p> <p>- April 27, 2025, at 05:57 Arm - Upper arm (rear) (right);</p> <p>- April 28, 2025, at 06:29 Arm - Upper arm (rear) (right);</p> <p>- April 29, 2025, at 06:28 Arm - Upper arm (rear) (right);</p> <p>- April 30, 2025, at 06:23 Arm - Upper arm (rear) (right);</p> <p>- May 3, 2025, at 06:55 Arm - left; and</p> <p>- May 4, 2025, at 05:55 Arm - left.</p> <p>During a follow-up concurrent interview and record review on May 9, 2025, at 2:27 p.m., with the DON, Resident 10's medical record, including the MARs dated March, April, and May 2025, were reviewed. The DON acknowledged nursing staff did not rotate insulin injection site locations on the above dates and times and stated the injection site locations should have been rotated for each dose of insulin.</p> <p>1d. A review of Resident 182's admission record indicated she was initially admitted to the facility on [DATE], and then admitted again on May 4, 2025, with diagnoses which included diabetes.</p> <p>A review of Resident 182's MARs dated from March 1, 2025 to May 8, 2025 indicated the following provider orders:</p> <p>- March 21, 2025 to April 3, 2025, Insulin Glargine (medication for diabetes) U100 (for every 1 ml of insulin, there are 100 units of insulin) Pen, Inject 28 units subcutaneously in the evening for diabetes. Check FS (fingertstick, method to check blood sugar) prior to administration. Hold (do not give insulin) if BS &amp;lt; 70 mg/dl or resident refusing meals. Rotate [injection] sites;</p> <p>(continued on next page)</p> |  |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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.

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>- March 21, 2025 to April 11, 2025, Humalog KwikPen Pen-injector 100 unit/ml, Inject as per sliding scale if 0 - 150 = 0 unit; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; BS &gt; 400 mg/dl or &lt; 70 mg/dl, notify MD., subcutaneously before meals for diabetes. Check BS fingerstick before insulin administration, document and rotate [injection] site;</p> <p>- April 4, 2025 to April 6, 2025, Lantus SoloStar Pen-Injector 100 units/ml (insulin glargine), Inject 26 units subcutaneously in the evening for diabetes, check BS fingerstick before insulin administration , hold if BS &gt; 70 mg/dl or patient refuses;</p> <p>- April 7, 2025 to April 11, 2025, Insulin Glargine U100 Pen, Inject 26 units subcutaneously in the evening related to diabetes, Hold for BS &gt; 70 mg/dl or resident is refusing meals;</p> <p>- May 5, 2025, Insulin Glargine Pen-Injector 100 units/ml, Inject 10 units subcutaneously in the evening related to diabetes. Check BS fingerstick before administration. Hold if BS &gt; 70 mg/dl or patient is refusing her meals or NPO. Document and rotate [injection] sites; and</p> <p>- May 5, 2025, Humalog KwikPen Pen-injector 100 unit/ml, Inject as per sliding scale if 0 - 140 = 0 unit; 141 - 180 = 3 units; 181 - 220 = 6 units; 221 - 260 = 9 units; 261 - 300 = 12 units; 301 - 340 = 15 units; BS &gt; 340 mg/dl give 18 units and notify MD. Also notify MD if BS &gt; 70 mg/dl, subcutaneously before meals and at bedtime related to diabetes. Check BS fingerstick before insulin administration, document and rotate [injection] site.</p> <p>Further review of Resident 182's MARs dated from March 1, 2025 to May 8, 2025, indicated nursing staff administered Insulin Glargine U100 Pen, Humalog KwikPen Pen-injector 100 unit/ml, Lantus SoloStar Pen-Injector 100 units/ml, and Insulin Glargine Pen-Injector 100 units/ml insulin by subcutaneous injections without rotating the injection site location for each dose according to the facility's</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure safe smoking practices were observed and implemented for two of 12 residents reviewed for smoking, when:</p> <ol style="list-style-type: none"> <li>1. Resident 29's cigarettes were not stored in the lock box provided by the facility; and</li> <li>2. Resident 84's smoking materials (cigarettes and lighter) were not stored in the lock box provided by the facility.</li> </ol> <p>These failures had the potential to result in accidents or injuries to the facility residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. On May 7, 2025, at 12:57 p.m., an observation was conducted with Resident 29. Resident 29 was observed in his room, sleeping in his bed. A pack of cigarettes was observed on Resident 29's nightstand open shelf, readily available.</li> </ol> <p>On March 7, 2025, at 1:05 p.m., an interview was conducted with the Activities Director (AD). The AD stated a Smoking Safety assessment is done for each resident upon admission and reviewed with nursing. The AD stated the decision whether a certain resident can smoke unsupervised or supervised is then reflected in the resident's Smoking Assessment and on the Smokers List. The AD stated all independent smokers (unsupervised) were provided with a lock box with a key or combination lock and the cigarettes need to be locked in the box.</p> <p>On March 7, 2025, at 1:30 p.m., the Smokers List with all the residents who smoke was reviewed. Resident 29 was identified as an independent smoker with a lock box.</p> <p>On March 7, 2025, at 1:43 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 4. LVN 4 went to Resident 29's room and observed the pack of cigarettes on the open shelf, readily available. LVN 4 stated the cigarettes pack should not have been left on the open shelf and should have been locked in Resident 29's lock box.</p> <p>On March 7, 2025, at 1:57 p.m., a concurrent observation and interview was conducted with the Activities Assistant (AA). The AA stated Resident 29's cigarettes pack was brought to the Activities office for safekeeping by LVN 4, because the cigarettes pack was not locked in his lock box.</p> <p>On March 7, 2025, at 2:01 p.m., an interview was conducted with the AD. The AD stated LVN 4 brought the cigarettes pack from Resident 29's room to the Activities office for safekeeping. The AD stated Resident 29's cigarettes pack should have been locked in Resident 29's lock box for safety and not be left on the open shelf.</p> <p>Resident 29's record was reviewed. Resident 29 was admitted at the facility on February 27, 2025, with diagnoses which included nicotine dependence on cigarettes. Resident 29's Smoking Safety assessment, dated February 27, 2025, indicated, .Resident may smoke independently .</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>The care plan for smoking, initiated on February 28, 2025, indicated: .Tobacco Resident at risk for injury related to resident choosing resident to smoke .Explain smoking policy to resident .Resident may smoke independently .Resident wishes to hold own smoking materials and has been provided a lock box to store smoking materials .</p> <p>2. On May 6, 2025, at 11:33 a.m., Resident 84 was observed sitting in the wheelchair. Resident 84 was awake and alert. In a concurrent interview with Resident 84, he stated he was allowed to keep his smoking materials and smoked unsupervised. Resident 84 showed his lighter and a cigarette tucked in his shirt.</p> <p>On May 7, 2025, at 1:05 p.m., the AD was interviewed. She stated upon admission, the nursing staff would ask resident if he or she smokes. The AD stated if the resident smokes, a visual assessment will be performed and the Smoking Safety Assessment will indicate if the resident can smoke independently. She stated a lock box with a key, or a combination lock was provided to independent smokers. She stated all smoking materials for independent smokers should be locked in the lock box. She also stated the activities assistant or herself conducted a monthly audit to check if residents complied with the policy.</p> <p>On May 7, 2025, at 3 p.m., with the AD, Resident 84 was interviewed. A pack of cigarettes were found stored in the drawer of the resident's nightstand. Resident 84 was observed with a lighter and a stick of cigarette in his hand.</p> <p>The AD asked Resident 84 for the lock box provided for his smoking materials. Resident 84 told the AD he did not have a lock box for his smoking materials. The AD asked for Resident 84's permission to search in his belongings to locate the lock box. Resident 84's lock box was found on top of the nightstand covered with a folded shirt. Resident 84's lock box was unlocked and had his watch inside.</p> <p>On May 7, 2025, at 3:28 p.m., during an interview with the AD, she stated Resident 84's smoking materials should have been stored in the lock box as per the facility policy.</p> <p>Resident 84's record was reviewed. Resident 84 was admitted to the facility on [DATE], with diagnoses which included nicotine (a highly addictive substance found in tobacco and vaping products) dependence. The history and physical dated January 2, 2025, indicated Resident 84 had the capacity to understand and make decisions.</p> <p>Resident 84's Smoking Safety Assessment, dated October 24, 2024, indicated, .Resident may smoke independently .</p> <p>A review of the care plan for tobacco use, revised March 27, 2023, indicated, .Resident is at risk for injury related to resident choses to smoke .Resident will Adhere to the Tobacco/Smoking Policies of the Facility . explain smoking policy to resident/responsible party .Resident may smoke independently .Resident wishes to hold/store own smoking materials and has been given a lock box .</p> <p>The facility policy and procedure titled, Resident Smoking, revised December 19, 2022, indicated, .It is the policy of this facility to provide a safe and healthy environment for residents .including safety as related to smoking .All safe smoking measures will be documented on each resident's care plan and communicated to all staff .</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on observation, interview, and record review, the facility failed to ensure provision of pharmacy services met the needs of the residents when three (3) of five (5) residents reviewed (Residents 94, 97, and 110) were missing documentation for the administration of controlled substance (CS, those with high potential for abuse and addiction) medications. The CS medication was signed out of the Controlled Drug Record (an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Records (MAR) to indicate it was administered to the residents.</p> <p>These failures resulted in inaccurate accountability of CS medications, which had the potential for misuse or diversion.</p> <p>Findings:</p> <p>1a. Resident 94 had a physician's order, dated April 10, 2025, for hydrocodone-acetaminophen (Norco, a potent controlled medication for pain) 5/325 mg (milligram, unit of measurement), 1 tablet by mouth every 4 hours as needed for moderate - severe pain.</p> <p>During a concurrent interview and record review on May 6, 2025, at 10:50 a.m., with Licensed Vocational Nurse (LVN) 5, a review of Resident 94's Count Sheet for Norco 5/325 mg and MAR dated May 2025, indicated the nursing staff signed out one tablet on May 3, 2025, at 9:09 a.m., but did not document the administration on the MAR. LVN 5 acknowledged one Norco 5/325 mg tablet for Resident 94 was unaccounted in May 2025, and stated nursing staff should have signed the count sheet and documented the administration in the MAR immediately.</p> <p>1b. Resident 110 had a physician's order, dated April 16, 2025, for oxycodone-acetaminophen (a potent controlled medication for pain) 10/325 mg, 1 tablet by mouth every 8 hours as needed for severe pain.</p> <p>During a concurrent interview and record review on May 6, 2025, at 11:14 a.m., with LVN 6, a review of Resident 110's Count Sheet for oxycodone-acetaminophen 10/325 mg and MARs dated April and May 2025, indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR:</p> <ul style="list-style-type: none"> <li>- April 20, 2025, at 00:00 (or 12 a.m.);</li> <li>- April 29, 2025, at 01:00 (or 1 a.m.); and</li> <li>- May 4, 2025, at 00:00 (or 12 a.m.).</li> </ul> <p>LVN 6 acknowledged two oxycodone-acetaminophen 10/325 mg tablets for Resident 110 were unaccounted in April 2025, and one tablet was unaccounted in May 2025. LVN 6 stated nursing staff should have signed the count sheet and documented the administration in the MAR immediately.</p> <p>1c. Resident 97 had a physician's order, dated April 23, 2025, Norco 5/325 mg, 1 tablet by mouth every 8 hours as needed for moderate - severe pain.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During a concurrent interview and record review on May 6, 2025, at 11:35 a.m., with LVN 3, a review of Resident 97's Count Sheet for Norco 5/325 mg and MAR dated April 2025, indicated the nursing staff signed out one tablet on April 16, 2025, at 10:56 a.m. but did not document the administration on the MAR. LVN 3 acknowledged one Norco 5/325 mg tablet for Resident 97 was unaccounted in April 2025, and stated nursing staff should have documented the administration in the MAR.</p> <p>During an interview on May 6, 2025, at 2:58 p.m. with the Director of Nursing (DON), the DON stated the expectation for CS medication accountability was for nursing staff to have documented on the Count Sheet and in the MAR immediately. The DON confirmed the discrepancies and acknowledged the missing documentation in the MAR for the dates and times as listed above for Residents 94, 97, and 110. The DON stated the CS medication administrations as listed above should have been documented on the MAR.</p> <p>A review of the facility's Policy and Procedure (P&amp;P) titled Medication Administration, revised date December 19, 2022, indicated, Sign MAR after administered .If medication is a controlled substance, sign narcotic book [count sheet] .</p> <p>A review of the facility's P&amp;P, titled Controlled Substance Administration &amp; Accountability, revised date December 19, 2022, indicated, All controlled substances obtained from non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided .In all cases, the dose noted on the usage form .must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record.</p> |  |  |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly medication regimen review (MRR) when Resident 4 received Seroquel (an antipsychotic medication for bipolar disorder, depression, and schizophrenia) without manufacturer specified monitoring.</p> <p>This failure had the potential for medications not being optimized for best possible health outcome, and increased risk for adverse effects for the residents.</p> <p>Finding:</p> <p>A review of Resident 4's admission record indicated she was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included schizoaffective disorder (mental health condition characterized by psychotic symptoms like hallucinations/delusions and mood episodes like mania or depression).</p> <p>A review of Resident 4's medical record indicated she had been receiving Seroquel in various doses since February 2022.</p> <p>A review of Resident 4's current Order Summary Report, dated May 9, 2025, indicated a provider order for: Seroquel 100 mg two times a day for visual hallucinations related to schizoaffective disorder, dated January 20, 2025.</p> <p>During a concurrent interview and record review on May 8, 2025, at 12:14 p.m., with the QA nurse, Resident 4's medical record was reviewed. The QA nurse confirmed Resident 4 was initially started on Seroquel on February 15, 2022. The QA nurse was unable to locate documentation of manufacturer's specified monitoring for lipids (blood cholesterol levels), TSH (a thyroid hormone), and Free T4 (the active form of the thyroid hormone in the blood). The QA nurse stated she would follow-up with medical records.</p> <p>During a follow-up interview on May 8, 2025, at 2:35 p.m., with the QA nurse, she verified no documentation of manufacturer's specified monitoring (lipids, TSH, or Free T4) during Seroquel use was found in Resident 4's medical records. QA nurse stated the Consultant Pharmacist (CP) should have made recommendations for the required monitoring.</p> <p>A review of the CP's monthly MRRs for Resident 4 dated January 30, 2025, February 27, 2025, March 31, 2025, and April 30, 2025, indicated there were no recommendations from the CP related to manufacturer's specified monitoring of lipids, TSH, or Free T4 during Seroquel use.</p> <p>During a concurrent interview and record review on May 8, 2025, at 4:38 p.m., with the Director of Nursing (DON), the DON acknowledged there was no documentation of the manufacturer's specified monitoring (lipids, TSH, or Free T4) during Seroquel use in Resident 4's medical records. The DON stated the CP should have identified and reported the irregularity during the monthly MRRs.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a telephone interview on May 9, 2025, at 2:30 p.m., with the CP in the presence of the DON, the CP acknowledged Resident 4 did not have documentation of manufacturer specified monitoring (lipids, TSH, or Free T4) during Seroquel use and stated it should have been monitored. The CP stated when manufacturer specified monitoring was not being done, it should have been identified and reported to the facility during the monthly MRRs.</p> <p>A review of the PI (Prescribing Information - reflects Food and Drug Administration's finding regarding the safety and effectiveness of the human prescription drug under the labeled conditions of use) for Seroquel, dated January 2025, provided by the facility, indicated, .fasting blood lipid testing at the beginning of, and periodically, during treatment .both TSH and free T4, in addition to clinical assessment, should be measured at baseline and at follow-up.</p> <p>Further review of the facility's policy and procedures titled Use of Psychotropic Medication, date revised December 19, 2022, indicated, The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as but not limited to .in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the residents comprehensive plan of care.</p> |  |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the lubricant eye drops solution was safely stored for one of 28 residents reviewed (Resident 186).</p> <p>This failure resulted in Resident 186 administering the eye drops solution without physician's order, self-administration assessment, and supervision. In addition, this placed Resident 186 at risk for unsafe medication administration and has the potential to alter the efficacy of the eye drops solution being stored at resident's bedside.</p> <p>Findings:</p> <p>On May 6, 2025, at 3: 11 p.m., Resident 186 was observed lying in bed awake, alert, oriented and able to verbalize her needs. One eye drops lubricant solution was observed on top of her overbed table. She stated her family member brought the eye drops from home. She stated she had used the eye drops for years as needed for her left eye. The eye drops lubricant solution was labeled .equate Dry Eye Relief, Lubricant Eye Drops Soothing Relief for dryness and irritation 0.5 FL OZ (Fluid Ounces - a unit of measurement) 15 ml (milliliter - a unit of measurement) .</p> <p>On May 7, 2025, at 9:20 a.m., Resident 186 was awake, lying in bed with breakfast tray on top of the overbed table. The eye drops lubricant solution was observed on top of the overbed table.</p> <p>On May 7, 2025, at 1:23 p.m., Resident 186 was observed lying in bed, awake, alert and able to verbalize her needs. She stated she had lunch. The eye drops lubricant solution was observed on top of the overbed table. She stated she had not used the eye drops today.</p> <p>On May 7, 2025, at 1:43 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she did not notice the eye drops solution on top of Resident 185's overbed table yesterday and today.</p> <p>On May 7, 2025, at 1:58 p.m., the Assistant Director of Nursing (ADON) was interviewed. The ADON stated the eye drops lubricant solution should not be stored at Resident 186's bedside. The licensed nurses are responsible in making sure there were no medications brought by family members at the bedside.</p> <p>On May 7, 2025, at 2:43 p.m., the Director of Nursing (DON) was interviewed. The DON stated the Licensed Nurses should have checked Resident 186's bedside for any medications from home.</p> <p>A review of Resident 186's record indicated Resident 186 was admitted to the facility on [DATE], with the diagnoses which included heart failure and kidney disease.</p> <p>Resident 186's BIMS (Brief Interview for mental Status - a cognitive tool assessment) Score of 13 (cognitively intact).</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of the electronic Medication Administration Record (MAR) for the month of May 2025, indicated Resident 186 had an order for Prednisolone Acetate Ophthalmic (a type of eye drops) Solution 1 %, instill 1 drop in right eye three times a day for inflammation .</p> <p>There was no physician's order for the eye drops lubricant solution found at Resident 186's bedside.</p> <p>A review of the facility's policy and procedure titled. Medication Storage, dated December 19, 2022, indicated, .All drugs and biologicals will be stored in locked compartments .medication carts .Only authorized personnel will have access to the keys .</p> |

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| <p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>Based on interview and record review, the facility failed to ensure the Dietary Supervisor (DSS - the position responsible for the day-to-day operation of the dietary department), met the educational requirements as outlined in the Federal Regulation, and California Health and Safety Code.</p> <p>Findings:</p> <p>According to California Code of Regulations, Title 22: Dietetic services are defined as the provision of safe, satisfying, and nutritionally adequate food for residents with appropriate staff, space, equipment, and supplies. Staffing requirements of dietetic services are such that if the position responsible for the day-to-day management of the department is not a registered dietitian there must be a full-time person who meets specific training requirements to be the dietetic services supervisor, responsible for the operation of the food service.</p> <p>According to the California, Health, and Safety Code - HSC &amp;sect; 1265.4: Qualifications of Dietary Supervisor:</p> <p>(b) The dietetic services supervisor shall have completed at least one of the following educational requirements:</p> <p>(1) A baccalaureate degree with major studies in food and nutrition, dietetics, or food management and has one year of experience in the dietetic service of a licensed health facility.</p> <p>(2) A graduate of a dietetic technician training program approved by the American Dietetic Association, accredited by the Commission on Accreditation for Dietetics Education, or currently registered by the Commission on Dietetic Registration.</p> <p>(3) A graduate of a dietetic assistant training program approved by the American Dietetic Association.</p> <p>(4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.</p> <p>(5) Is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>(6) A graduate of a state approved program that provides 90 or more hours of classroom instruction in dietetic service supervision, or 90 hours or more of combined classroom instruction and instructor led interactive Web-based instruction in dietetic service supervision.</p> <p>(7) Received training experience in food service supervision and management in the military equivalent in content to paragraph (2), (3), or (6).</p> <p>On May 6, 2025, at 8:35 a.m., an interview was conducted with the Dietary Supervisor (DSS). The DSS stated he had been working in this facility for five years. The DSS stated he only had work experience and did not have any qualifications.</p> <p>On May 6, 2025, at 2:29 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated she worked as a full time RD in this facility. The RD stated her day-to-day responsibility was to perform clinical nutrition duties. She also indicated her only responsibility for dietetic services is to provide general oversight such as performing monthly kitchen sanitation inspections, test trays and in-service training, when requested. The RD stated the DSS was the person responsible for the day-to-day operation and supervision of the dietetic services department.</p> <p>On May 7, 2025, at 1:24 p.m., an interview was conducted with the Administrator (ADM) and the DSS. The ADM confirmed the DSS was the person responsible for the day-to-day operation and supervision of dietetic services. The ADM was not aware the DSS did not have the required State qualifications. The ADM confirmed with the DSS he did not have any qualifications.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled, FOOD AND NUTRITION SERVICES ORGANIZATION CHART, revised dated 9/11/2018, the P&amp;P indicated, .POLICY: The Food and Nutrition Services Department should function within an organizational structure with sufficient staff to carry out the functions of the food and nutrition service. The organizational chart should explain the departmental chain of command. Communication, authority, and responsibility should be identified through the departmental organization structure. PROCEDURE .3. Cooks, Dietary Assistants, Diet Aides, Dishwashers, .are responsible to the Director of Food and Nutrition Services.5. The Director of Food and nutrition Services has responsibility for overall operation of the Food and Nutrition Services Department.</p> <p>A review of the facility's Job Description titled, DIRECTOR OF FOOD AND NUTRITION SERVICES DEPARTMENT, revised date 9/22/2022, indicated, .PRIMARY RESPONSIBILITY Organizes, coordinates, and supervises the Food and Nutrition Services Department personnel, work, food production and food service. QUALIFICATIONS .EDUCATION: .b. In States that have established standards for Food Service Managers (Dietary Supervisor) or Director of Food and nutrition Services, meets State requirements for Directors of Food and Nutrition Services; .SPECIFIC RESPONSIBILITIES 1. Supervise resident meal service planning and programs.2. Supervise personnel functions of Food and Nutrition Service Department.9. The Director of Food and Nutrition Services should provide the community with their current licenses and record of continuing education.</p> |  |  |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>Based on observation, interview, and record review the facility failed to ensure Food and Nutrition Services staff were trained and competent to carry out the functions of the department safely and effectively when:</p> <ol style="list-style-type: none"> <li>Multiple Food and Nutrition Services staff, including the Registered Dietitian, did not follow professional standards of practice using three separate steps (wash, rinse and sanitize) to clean and sanitize food contact surface.</li> <li>Failure to properly clean and sanitize food contact surface results in growth of microorganisms on food contact surface and could cross-contaminate food;</li> <li>Two staff members (Cook 1 and [NAME] 2) did not know the correct concentration of the sanitizer (sanitizing solution used for sanitizing food contact surfaces);</li> <li>A staff member (Dietary Aide 4) did not follow manufacturer's guideline time length in dipping the test strip into the sanitizer for testing the concentration of the sanitizer;</li> <li>Multiple Food and Nutrition Services staff did not know the correct concentration of the Dishwasher sanitizer; and</li> <li>Multiple Food and Nutrition Services staff did not recognize the dishwasher was operating inadequate manufacturer's guideline temperature.</li> </ol> <p>These failures had the potential to result in foodborne illnesses (are illnesses that results from ingesting contaminated foods) for 136 of 136 sampled residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a review of the U.S. FDA (Food and Drug Administration) Food Code 2022, Annex 3 Section 4-501.18 Warewashing Equipment, Clean Solutions, the Food Code indicated, Warewashing means the cleaning and SANITIZING of UTENSILS and FOOD-CONTACT SURFACES of EQUIPMENT. Failure to maintain clean wash, rinse, and sanitizing solutions adversely affects the warewashing operation. Equipment and utensils may not be sanitized, resulting in subsequent contamination of food.</li> </ol> <p>On May 5, 2025, at 10:05 a.m., an interview was conducted with [NAME] 3(CK 3) in the kitchen. CK 3 was asked to demonstrate how to clean and sanitize soiled stationary mixer. CK 3 stated she cleaned and sanitized the soiled mixer with soap and water and then sanitize with sanitizer.</p> <p>On May 5, 2025, at 10:25 a.m., a concurrent observation and interview was conducted with DA 5 in the dishwashing area. Concurrent observation and interview with CK 5, CK 5 demonstrated she only used sanitizer to clean the soiled meal carts.</p> <p>On May 5, 2025, at 10:51 a.m., an observation was conducted with CK 1 in the kitchen at cook area. CK 1 was observed cleaning the soiled working surface after he prepared Hamburger patties. CK 1 only used sanitizer to clean the working surface.</p> <p>(continued on next page)</p> |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On May 6, 2025, at 11:05 a.m., an interview was conducted with Dietary Aide 6 (DA 6) in the dishwashing area. DA 6 was asked to demonstrate how to clean and sanitize soiled meal carts. DA 6 demonstrated she was using sanitizer only to clean the soiled meal cart.</p> <p>On May 6, 2025, at 11:18 a.m., an observation was conducted with CK 4 at the cook area. CK 4 was observed only using the sanitizer to clean the working surface after she finished preparing the food.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the Registered Dietitian (RD) and Dietary Supervisor (DSS). The RD and DSS were asked to describe the correct procedures for cleaning and sanitizing food contact surface. The DSS stated first step was removing debris with disposable towel and then sanitize with sanitizer. The RD stated first procedure was removing dirt on the soil working surface with cloth and then sanitize with sanitizer. The RD stated that not properly cleaning and sanitizing food contact surfaces could promote bacteria and virus growth and could cause cross contamination which could lead to foodborne illnesses.</p> <p>2. A review of the sanitizer manufacturer's guidelines posted above three compartment sinks (sink used to wash, rinse and sanitizing kitchenware). The sanitizer manufacturer's guidelines indicated, Solution (sanitizer) should be between 200-400 parts per million (ppm - a unit of measurement)</p> <p>On May 5, 2025, at 9:58 a.m., an interview was conducted with [NAME] 1 (CK 1). CK 1 was asked to demonstrate how to check the concentration of the sanitizer. CK 1 stated the concentration of sanitizer should be 200 -300 ppm, 400 ppm was not good because it was too concentrated.</p> <p>On May 5, 2025, at 11:11 a.m., an interview was conducted with CK 2. CK 2 was asked to demonstrate how to check the concentration of sanitizer. CK 2 stated the concentration of sanitizer should be 200 -300 ppm.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the RD and the DSS. The DSS stated sanitizer should be 200- 400 ppm.</p> <p>During a review of the facility's policy titled SANITIZERS, date revised 8/15/2017, the policy indicated, . Introduction: It is critical that staff not only know what type of sanitizers are being used, but are proficient in using sanitizer products. Proper sanitation is an important step to protecting residents from foodborne illness. Sanitizer .kitchen staff should: 1) Have read the manufacturer's guide, for use and testing and have demonstrated competency.</p> <p>3. A review of the sanitizer test strip manufacturer's guidelines printed on the test strip container was conducted. The test strip manufacturer's guidelines indicated, Immerse strip for 10 seconds</p> <p>On May 5, 2025, at 9:58 a.m., a concurrent observation and interview was conducted with Dietary Aide 4 (DA 4). DA 4 was asked to demonstrate how to check the concentration of sanitizer. DA 4 was observed dipping the test strip into sanitizer for 3 seconds.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the RD. The RD stated dietary staff should dip the test strip for 10 seconds to check the concentration of the sanitizer. The RD explained if the dietary staff did not follow manufacturer's guidelines time length to dip into the sanitizer, it could result false reading of the concentration sanitizer.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During a review of the facility's policy titled SANITIZERS, date revised 8/15/2017, the policy indicated, . Introduction: It is critical that staff not only know what type of sanitizers are being used, but are proficient in using sanitizer products. Proper sanitation is an important step to protecting residents from foodborne illness. Sanitizer .kitchen staff should: 1) Have read the manufacturer's guide, for use and testing and have demonstrated competency.</p> <p>4. A review of the dishwasher manufacturer's guidelines indicated, Required: 50 ppm available Chlorine (chemical solution used to sanitize dishes).</p> <p>On May 5, 2025, at 10:31 a.m., an interview was conducted with DA 2, DA 3 and DA 5 at the dish washing area. DA 2, DA 3 and DA 5 stated dishwasher chlorine needed to be 100- 200 ppm.</p> <p>On May 6, 2025, at 11:05 a.m., an interview was conducted with DA 6 at the dishwashing area. DA 6 was asked to demonstrate how to check the concentration of chlorine. DA 6 dipped the test strip and stated chlorine needed to be 100 -200 ppm.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the RD and the DSS. The DSS stated dishwasher chlorine need to be 50 -100 ppm. The RD stated staff should follow manufacturer guidelines and the chorine should be 50- 100 ppm. The RD explained 100 -200 chlorine concentration was too high which would cause white stain on dishes and strong chlorine odor on dishes.</p> <p>During a review of the facility's policy titled SANITIZERS, date revised 8/15/2017, the policy indicated, . Introduction: It is critical that staff not only know what type of sanitizers are being used, but are proficient in using sanitizer products. Proper sanitation is an important step to protecting residents from foodborne illness. Criteria for Sanitizer in the Dishmachine (Dishwasher): Dishmachine temperatures and ppm per requirements: a. Check what the temperature requirements are for the dishmachine. Also know what type of sanitizer is used in a cold temperature dishmachine.c. Generally, for a cold temperature dishmachine, .the sanitizer is chlorine based, the litmus must test at 50 -100 ppm. kitchen staff should: 1) Have read the manufacturer's guide, for use and testing and have demonstrated competency.</p> <p>5. A review of the dishwasher manufacturer's guidelines indicated, Wash Temperature: 120 degrees Fahrenheit (&amp;deg;F - a unit of measurement) minimum.</p> <p>On May 5, 2025, at 9:34 a.m., a concurrent interview and observation during the dishwasher operation was conducted with DA 2. The dishwasher temperature gauge indicated, 114 &amp;deg;F ; follow up on 9:35 a.m., the dishwasher temperature gauge indicated, 115 &amp;deg;F during operation; follow up on 9:38 a.m., the dishwasher temperature gauge indicated, 110 &amp;deg;F during operation. Confirmed with DA 2, dishwasher temperature gauge indications were lower than 120 &amp;deg;F.</p> <p>On May 5, 2025, at 10:28 a.m., a concurrent interview and observation during the dishwasher operation was conducted with DA 3. The dishwasher temperature gauge indicated, 108 &amp;deg;F ; follow up on 10:30 a.m., the dishwasher temperature gauge indicated, 108 &amp;deg;F during operation; follow up on 10:38 a.m., the dishwasher temperature gauge indicated, 100 &amp;deg;F during operation; follow up on 10:54 a.m., the dishwasher temperature gauge indicated, 110 &amp;deg;F during operation. Confirmed with DA 3, dishwasher temperature gauge indications were lower than 120 &amp;deg;F.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On May 5, 2025, at 11:48 a.m., an observation was conducted with the dishwasher during operation. The dishwasher temperature gauge indicated, 114 &amp;deg;F .</p> <p>A review of the facility's dishwasher daily log indicated, Wash Temperature: 120 -140 &amp;deg;F</p> <p>During a review of the facility's policy titled Dishwasher Temperature, date revised 12/19/2022, the policy indicated, Policy: It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperature. Policy Explanation and Compliance Guidelines: .2. Manufacturers' instructions shall be followed for machine washing and sanitizing.</p> <p>During a review of the facility's policy titled SANITIZERS, date revised 8/15/2017, the policy indicated, . Introduction: It is critical that staff not only know what type of sanitizers are being used, but are proficient in using sanitizer products. Proper sanitation is an important step to protecting residents from foodborne illness. Criteria for Sanitizer in the Dishmachine: Dishmachine temperatures and ppm per requirements: a. Check what the temperature requirements are for the dishmachine. Also know what type of sanitizer is used in a cold temperature dishmachine.c. Generally, for a cold temperature dishmachine, the wash temperature should be 120 -150 &amp;deg;F .kitchen staff should: 1) Have read the manufacturer's guide, for use . and have demonstrated competency.</p> |  |  |

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| <p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on dietary observations, dietary staff interviews and record reviews, the facility failed to ensure:</p> <ol style="list-style-type: none"> <li>[NAME] 2 followed the recipe when preparing an alternative meal during lunch on 5/5/25;</li> <li>[NAME] 4 followed the recipe when preparing pureed bread during lunch on 5/6/25; and</li> <li>[NAME] 4 followed the recipe when preparing Buttered Carrots during lunch on 5/6/25.</li> </ol> <p>Failure to follow standardize recipes may result in the preparation of a meal that did not meet the physician ordered diet. Failure to follow recipes may also result in a product that is not palatable which may result in decreased meal intake in a medically vulnerable residents.</p> <p>Findings:</p> <p>A standardized recipe is a set of written instructions used to consistently prepare a known quantity and quality of food for a specific location. A standardized recipe will produce a product that is close to identical in taste and yield and nutritional value every time it is made, no matter who follows the directions (Pennsylvania University, 2024).</p> <p>On May 5, 2025, at 12:00 p.m., a concurrent observation and interview was conducted with [NAME] 2 (CK 2) at the cook area in kitchen. CK 2 was observed preparing Cheese quesadilla. CK 2 stated she was making six serving Cheese Quesadilla as alternative meal (substitution meal that serve to a resident if resident does not like provided menu on the day). CK 2 was observed using her hand, grabbed some shredded cheese from a container and sprinkled the shredded cheese on top of flour tortilla to make cheese quesadilla. CK 2 stated she needed to use a measuring scoop to scoop out 3 oz of shredded cheese to make cheese quesadilla. CK 2 was observed not using the recipe while making cheese quesadilla.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated cooks needed to use measuring equipment to measure ingredients instead of using hands and should be following the recipe. The RD explained without measuring the cheese for the cheese quesadilla, cooks would not be putting the right amount of cheese which could alter the nutrition values. The RD claimed this could result in residents over or under obtained their calories, protein and nutrients needed.</p> <p>During a review of the facility provided recipe titled, Grilled Cheese Quesadilla - 2 oz, the recipe indicated, . Sprinkle &amp;frac12; cup (2 oz) shredded cheese on top of tortilla .</p> <p>During a review of the facility's policy titled Standardized RECIPES, revised date 8/31/2013, the policy indicated, Standardized recipes will be used for all products prepared .Procedure: 1. Use standardized recipes .9. Recipes note how to prepare the food items in order to preserve vitamins, taste, and appearance</p> <p>(continued on next page)</p> |  |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>4070 Jurupa Avenue<br>Riverside, CA 92506 |  |
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| <p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During a review of the facility's policy titled Food Preparation Guidelines, revised date 12/19/2022, the policy indicated, Policy: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .Policy Explanation and Compliance Guidelines: 1. The cook, shall prepare menu items following the facility's .standardized recipes. 2. Food shall be prepared by methods that conserve nutrition value .This includes, .Preparing foods as directed.</p> <p>2. On May 6, 2025, at 10:49 a.m., a concurrent observation and interview was conducted with CK 4 at the cook area in the kitchen. CK 4 was observed preparing pureed bread. CK 4 was observed pouring two cartoon 32 fluid ounces (oz- a unit of measurement) soy milk into the blender. CK 4 stated she put 22 pieces of bread into the blender. Then CK 4 blended the bread and soy [NAME] together. CK 4 stated she added 1&amp;frac12; cup of thickener into the end product of pureed bread. During the whole process, CK 4 was observed not following the pureed bread products recipe.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated CK 5 should follow the recipe while preparing the pureed bread otherwise it resulted in alternating the nutrition values of the pureed bread.</p> <p>During a review of the facility provided recipe titled, PUREED BREAD PRODUCTS, the recipe indicated, Ingredients: Bread product 5 each, *Milk Alternative &amp;frac34; cup, ** Food Thickener 1&amp;frac12; teaspoon. Directions 1.Gradually add liquid to bread while processing and PROCESS UNTIL SMOOTH. ALL LIQUID MAY NOT BE REQUIRED. 2. If consistency does not need thickener, DO NOT ADD. If thickener is needed, FOR BEST RESULTS, alternate adding thickener with processing, checking product consistency periodically until smooth. NOTE *Volume of liquid required may vary slightly, depending on the texture of the product. **Amount of thickener may need to be adjusted. Start with 1&amp;frac12; teaspoon and add more gradually until desired texture is achieved.</p> <p>During a review of the facility's policy titled Standardized RECIPES, revised date 8/31/2013, the policy indicated, Standardized recipes will be used for all products prepared .Procedure: 1. Use standardized recipes .9. Recipes note how to prepare the food items in order to preserve vitamins .</p> <p>During a review of the facility's policy titled Food Preparation Guidelines, revised date 12/19/2022, the policy indicated, Policy: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .Policy Explanation and Compliance Guidelines: 1. The cook, shall prepare menu items following the facility's .standardized recipes. 2.Food shall be prepared by methods that conserve nutrition value .This includes, .Preparing foods as directed.</p> <p>3. On May 6, 2025, at 11:35 a.m., a concurrent food production observation and interview was conducted with CK 4 at the cook area in the kitchen. There were three boiled carrots on the stove. CK 4 was observed pouring an unmeasured amount of yellow liquid into each pan of boiled carrots. CK 4 stated the yellow liquid was margarine and she was preparing Buttered Carrots for lunch.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the Registered Dietitian (RD). The RD explained without measuring the amount of margarine put into the Buttered Carrots, it resulted in altering the nutrition value of the Buttered Carrots. The RD stated the bottom line was dietary staff including cooks should follow recipes to make sure preparing the foods in a manner to enhance residents' nutrition needs according to planned menu.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During a review of the facility provided recipe titled, Buttered Carrots, the recipe indicated, Ingredients: Sliced Carrots 5 pound, Margarine 2 oz for 25 servings</p> <p>During a review of the facility's policy titled Standardized RECIPES, revised date 8/31/2013, the policy indicated, Standardized recipes will be used for all products prepared .Procedure: 1. Use standardized recipes .9. Recipes note how to prepare the food items in order to preserve vitamins .</p> <p>During a review of the facility's policy titled Food Preparation Guidelines, revised date 12/19/2022, the policy indicated, Policy: It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .Policy Explanation and Compliance Guidelines: 1. The cook, shall prepare menu items following the facility's .standardized recipes. 2. Food shall be prepared by methods that conserve nutrition value .This includes, .Preparing foods as directed.</p> |  |  |

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| <p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the appropriate food textures was provided when two residents (Resident 15 and 81) out of two sampled residents who receives Soft and Bite-Sized diet (a diet with food texture need to chop up or pureed into small piece for residents who have limited swallowing ability) received a regular texture bread stuffing without gravy for lunch on 5/5/2025.</p> <p>This failure had the potential to place the residents at risk of choking.</p> <p>Findings:</p> <p>A review of the facility [NAME] Spreadsheet (the document used to guide dietary staff on food items, portions, and therapeutic diet) dated on May 5, 2025, indicated, Soft and Bite-Sized diet: served puree bread stuffing with 1 ounce smooth thick gravy.</p> <p>On May 5, 2025, at 12:10 p.m., an observation was conducted at Trayline (a system of food preparation in which trays move along an assembly line) in the kitchen. Checking each food items were going to serve at the steam table. There was no puree bread stuffing available at the steamtable.</p> <p>On May 5, 2025, at 1:03 p.m., an observation was conducted with Resident 15 in the dining room. Resident 15's tray card indicated, Soft and Bite sized diet. Resident 15 was being served regular bread stuffing without gravy.</p> <p>On May 5, 2025, at 1:05 p.m., an observation was conducted with Resident 81 in the dining room. Resident 81's tray card indicated, Soft and Bite sized diet. Resident 81 was being served regular bread stuffing without gravy.</p> <p>On May 7, 2025, at 1:59 p.m., an interview was conducted with the RD. The RD stated cooks should follow [NAME] Spreadsheet to serve the food items as indicated on the [NAME] Spreadsheet. The RD stated serving regular texture food items to Soft and Bite sized diet residents could had potential risk of choking, and decreased meal intake.</p> <p>A review of the facility's policy titled Food Preparation Guidelines, revised date 12/19/2022, indicated, It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .Policy Explanation and Compliance Guidelines: 1. The cook, shall prepare menu items following the facility's written menus .4. Food shall be provided in a form (i.e. regular, cut, chopped, ground, pureed) that meets each resident's individual needs in accordance with his or her assessment, Diet Diagnosis (RX) and care plan.</p> <p>(continued on next page)</p> |  |  |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some                           | A review of the facility's policy titled THERAPEUTIC AND TEXTURE-MODIFIED DIETS, date 2021, the policy indicated, .Texture-modified diets are prepared and served as prescribed by the attending physician. These diets are also: Planned and approved by a Registered Dietitian (RD). Included on the menu extension and individual tray card .DEFINITIONS: .A texture-modified diet means one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physician's order. A texture-modified diet is a mechanically altered diet, and is also defined as soft solids, pureed foods, ground meats, and thickened liquids. Procedure: .The RD, Director of Food and Nutrition . should frequently observe preparation and serving of meals for the following: a. The correct type .for texture-modified preparations. b. The correct type .for .serving of all diets. c. The daily spreadsheet extension is posted on the service line. Each food item is prepared and served accordingly for .texture modifications as indicated by .daily spreadsheet. |  |  |

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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>Based on observation, interview, and record review, the facility failed to follow the physician's prescribed diet order when:</p> <ol style="list-style-type: none"> <li>Heart Healthy diet was given the food item that was not consistent with the [NAME] Spreadsheet; and</li> <li>Renal and Liberal House Renal diets were given the food item that was not consistent with the [NAME] Spreadsheet on 5/5/25 and 5/6/25.</li> </ol> <p>These failures had the potential to negatively impact the residents' nutritional status and further compromising resident's medical status.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>A review of the facility [NAME] Spreadsheet (the document used to guide dietary staff on food items, portions, and therapeutic diet) dated on May 5, 2025, indicated, Heart Healthy diet served seasoned Pasta.</li> </ol> <p>On May 5, 2025, at 12:10 p.m., during trayline (a system of food preparation in which trays move along an assembly line) observation in the kitchen. Checking each food items were going to serve at the steamtable. There was no pasta available at the steamtable.</p> <p>On May 5, 2025, at 12:56 p.m., an observation was conducted with Resident 66 in the dining room. Resident 66's meal ticket indicated, Heart Healthy diet. Resident 66 were being served regular bread stuffing instead of seasoned Pasta.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated cooks should follow the cook spreadsheet to serve the food items as indicated on the spreadsheet. The RD explained serving the wrong food items on therapeutic diet could affect the health being of the residents.</p> <p>On May 7, 2025, at 2:09 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated dietary staff should follow the cook spreadsheets providing the food items on therapeutic diets as ordered by the doctors. The DON explained doctor ordered therapeutic diets for the residents as part of the treatment. The DON stated not following therapeutic diets would have a negative impact on residents' health being.</p> <p>A review of the facility's provided physician diet orders, dated 5/6/2025, the physician diet orders indicated six residents (Residents 4, 18, 29, 65, 66, and 107) on Heart Healthy diet.</p> <p>A review of the facility provide diet definition titled, Heart Healthy Diet, indicated, The Hearth Healthy (Low Fat/Low Cholesterol/ 2-2.5 gram Sodium) diet is intended for lowering the risk of developing heart disease by limiting the intake of fat, cholesterol and sodium.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A review of the facility's policy titled THERAPEUTIC AND TEXTURE- MODIFIED DIETS, date 5/7/2021, the policy indicated, Therapeutic .diets are prepared and served as prescribed by the attending physician. These diets are also: Planned and approved by a Registered Dietitian (RD). Included on the menu extension and individual tray card .DEFINITIONS: A therapeutic diet means a diet ordered by a physician as part of treatment for disease or clinical condition, or to eliminate or decrease specific nutrients in the diet (e.g., sodium), or to increase specific nutrients in the diet (e.g., potassium). PROCEDURE: .The RD, Director of Food and Nutrition .should frequently observe preparation and serving of meals for the following: a. The correct type .for therapeutic .preparations. b. The correct type .for .serving of all diets. c. The daily spreadsheet extension is posted on the service line. Each food item is prepared and served accordingly for the therapeutic .as indicated by .daily spreadsheet.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled, THERAPEUTIC DIETS , revised date 4/30/2021, the P&amp;P indicated, POLICY: Therapeutic diets are prepared and served as prescribed by the attending physician .1. Therapeutic diets are planned, and served 2. Therapeutic diets are reflected on the menu extension (Cook spreadsheets) .PROCEDURE. The RD should frequently observe preparation and serving of meals. The RD and Director of Food and Nutrition Services must see that: a. The correct type .of food .for therapeutic diet preparation. B. The correct type for .serving of all diets.d. Each Food and Nutrition Service staff member involved with serving must refer to and follow the appropriate therapeutic diet on the daily menu.h. Correct diet served to residents.</p> <p>2. A review of the facility [NAME] Spreadsheet dated on May 5, 2025 and May 6, 2025, indicated, Liberal House Renal diet and Renal diet served Bread or Roll (no whole gain).</p> <p>On May 5, 2025, at 11:13 a.m., a concurrent food production observation and interview was conducted with CK 1 at the cook area. CK 1 was observed preparing wheat roll for lunch. CK 1 stated all residents would get wheat roll except one resident who got white bread because she allergic to wheat.</p> <p>On May 5, 2025, at 3:21 p.m., a concurrent food production .observation and interview was conducted with CK 2 at the cook area. CK 2 was observed preparing wheat roll for dinner. CK 2 stated she was preparing wheat roll for all residents except one resident who has allergy to wheat, so she got white bread.</p> <p>On May 6, 2025, at 11:44 a.m., a concurrent food production observation and interview was conducted with CK 4 at the cook area. CK 4 was observed preparing wheat roll for lunch. CK 4 stated she was preparing wheat roll for all residents except one resident who got white bread due to her allergy to wheat.</p> <p>On May 6, 2025, at 12:30 p.m., a concurrent observation and interview was conducted with Assistant Dietary Supervisor (ADS) and CK 4 at Trayline. Only wheat roll was available in Trayline. CK 4 confirmed all food items needed to be serve were on Trayline. The ADS confirmed all residents would be served wheat roll except one resident who has allergy to wheat got white bread.</p> <p>On May 6, 2025, at 3:57 p.m., a concurrent interview and [NAME] Spreadsheet dated 5/5/25 and 5/6/25 review was conducted with the Registered Dietitian (RD). The RD stated Renal diet residents could not have wheat roll because it could effect their blood electrolyte. The RD stated cooks should follow spreadsheet to provide food items as indicated on therapeutic diet.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On May 7, 2025, at 2:09 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated dietary staff should follow cook spreadsheets providing the food items on therapeutic diet as ordered by the doctors. The DON explained doctor ordered therapeutic diet for the residents as part of the treatment. Not following Renal diets effect the renal functions of residents which could lead to Renal disease complications, edema and dialysis.</p> <p>A review of the facility's provided physician diet orders, dated 5/7/2025, indicated, five residents (Residents 11, 41, 46, 73 and 89) on Liberal House Renal diet.</p> <p>A review of the facility's provided physician diet orders, dated 5/6/2025, indicated, one residents (Resident 10) on Renal diet.</p> <p>A review of the facility's policy titled THERAPEUTIC AND TEXTURE-MODIFIED DIETS, date 5/7/2021, indicated, Therapeutic .diets are prepared and served as prescribed by the attending physician. These diets are also: Planned and approved by a Registered Dietitian (RD). Included on the menu extension and individual tray card .DEFINITIONS: A therapeutic diet means a diet ordered by a physician as part of treatment for disease or clinical condition, or to eliminate or decrease specific nutrients in the diet (e.g., sodium), or to increase specific nutrients in the diet (e.g., potassium). PROCEDURE: .The RD, Director of Food and Nutrition .should frequently observe preparation and serving of meals for the following: a. The correct type .for therapeutic .preparations. b. The correct type .for .serving of all diets. c. The daily spreadsheet extension is posted on the service line. Each food item is prepared and served accordingly for the therapeutic .as indicated by .daily spreadsheet.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled, THERAPEUTIC DIETS , revised date 4/30/2021, the P&amp;P indicated, POLICY: Therapeutic diets are prepared and served as prescribed by the attending physician .1. Therapeutic diets are planned, and served 2. Therapeutic diets are reflected on the menu extension (Cook spreadsheets) .PROCEDURE. The RD should frequently observe preparation and serving of meals. The RD and Director of Food and Nutrition Services must see that: a. The correct type .of food .for therapeutic diet preparation. B. The correct type for .serving of all diets.d. Each Food and Nutrition Service staff member involved with serving must refer to and follow the appropriate therapeutic diet on the daily menu.h. Correct diet served to residents.</p> |  |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary environment, prepare, and served food in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> <li>1. Raw meats were holding for extended periods of time for thawing;</li> <li>2. Multiple pieces of equipment that were not clean to sight and/or touch found in kitchen;</li> <li>3. Multiple areas and pieces of equipment covered with dust were found in kitchen;</li> <li>4. Storage shelves at dry storage did not have smooth surface;</li> <li>5. Screened door at dry storage had gap;</li> <li>6. Two non-dietary staff entered the kitchen without hairnets;</li> <li>7. Personnel belongings found at dry storage;</li> <li>8. Dry storage shared with dietary staff break room; and</li> <li>9. Expired foods found at resident's refrigerator.</li> </ol> <p>These failures had the potential to result in cross contamination (bacteria are unintentionally transferred from one substance or object to another with harmful effect) and foodborne illnesses (are illnesses that results from ingesting contaminated foods) for 136 of 136 sampled residents who received foods from the kitchen.</p> <p>Findings:</p> <p>1. On May 5, 2025, at 3:45 p.m., a concurrent observation and interview was conducted with the Registered Dietitian (RD) at the walk in refrigerator. There were two trays of 4 oz individual package beef patties stored on the bottom shelves for thawing. One of the beef patties tray labeled with dated prepared date: 5/1/25, used by date: 5/8/25. It was also noted there was bloody liquid in the bag. Another tray of beef patties labeled with dated with prepared date: 5/5/25, used by date: 5/12/25.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with the Dietary Supervisor (DSS). The DSS stated beef thawing under refrigerator was no more than 3 days. The DSS explained holding raw meat for extended periods of time may result in inadvertent microbial growth.</p> <p>A review of the facility's policy titled MEAT COOKERY AND STORAGE, revised date 5/20/2020, indicated, . meat which needs defrosting should be pulled three days prior to service and defrosted in a dry, cool area at 41 degrees Fahrenheit (&amp;deg;F - a unit of measurement) or less.</p> <p>(continued on next page)</p> |  |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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. |   |  |  |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A review of the facility's policy titled Food Safety and Food Storage, revised date 11/4/2024, indicated, .Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be flowed throughout the facility's entire food handling process.Storage of food in a manner that helps prevent deterioration . of the food, including from growth of microorganisms.</p> <p>2. On May 5, 2025, at 9:17 a.m., a concurrent observation and interview was conducted with the DSS in the kitchen. The hot water dispenser was observed to have white grime buildup. The DSS confirmed white grime was calcium buildup and had potential risk in getting into the water.</p> <p>On May 5, 2025, at 9:25 a.m., during observation, the inside of the microwave in the kitchen, had grime buildup.</p> <p>On May 5, 2025, at 9:28 a.m., during observation, the plate based warmer in the kitchen had grime buildup.</p> <p>On May 5, 2025, at 9:52 a.m., during observation, the stationary mixer in the kitchen had grime buildup.</p> <p>On May 5, 2025, at 3:33 p.m., a concurrent observation and interview was conducted with the RD. The RD verified those equipment (microwave, plate based warmer, and stationary mixer) had buildup. The RD stated equipment in the kitchen should be kept clean to prevent cross contamination.</p> <p>On May 5, 2025, at 3:45 p.m., a concurrent observation and interview was conducted with the RD at the walk in refrigerator. The RD confirmed walk in refrigerator's gasket had black grime buildup, and the storage shelves were found grayish, whitish fussy, black particles buildup.</p> <p>A review of the facility's policy titled Sanitation Inspection, revised date 12/19/2022, indicated, It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. Policy Explanation and Compliance Guidelines: 1. All food service areas shall be kept clean, sanitary .</p> <p>3. A review of the U.S. Federal and Drug Administration (FDA) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces , the Food code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests.</p> <p>On May 5, 2025, at 9:15 a.m., a concurrent observation and interview was conducted with the DSS. The entrance kitchen's door frame was observed covered with black debris. The DSS stated it was dust on the entrance kitchen's door frame.</p> <p>On May 5, 2025, at 3:33 p.m., a concurrent observation and interview was conducted with the RD in the kitchen. The RD verified the back kitchen's door frame covered with dust and the fan in the dishwashing area covered with dust directly blew towards the cleaned dishes. The RD stated kitchen should be kept clean to prevent cross contamination.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On May 6, 2025, at 10:36 a.m., a concurrent observation and interview was conducted with the DSS in the kitchen. [NAME] and black debris was observed hanging on the back of the oven. The DSS confirmed those brown and black debris was dust.</p> <p>A review of the facility's policy titled Sanitation Inspection, revised date 12/19/2022, indicated, It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. Policy Explanation and Compliance Guidelines: 1. All food service areas shall be kept clean, sanitary .</p> <p>4. A review of the U.S. Federal and Drug Administration (FDA) Food Code 2022, 4-101.11 Equipment, indicated, FOOD-CONTACT SURFACES of EQUIPMENT . to have a SMOOTH, EASILY CLEANABLE surface, . Resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition</p> <p>On May 5, 2025, at 9:15 a.m., a concurrent observation and interview was conducted with the RD at the dry storage room in the kitchen. The storage shelves was observed with brown grime buildup with losing coating which did not have smooth surface. The RD stated the storage shelves were worn out and old which needed to be replaced.</p> <p>5. On May 6, 2025, at 2:20 p.m., a concurrent observation and interview was conducted with the RD at the dry storage room in the kitchen. The screened door was observed with gap. The RD stated insects could entered through the door gap.</p> <p>A review of the facility's policy titled Sanitation Inspection, revised date 12/19/2022, the policy indicated, It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. Policy Explanation and Compliance Guidelines: 1. All food service areas shall .protected from rodents, roaches, flies and other insects.</p> <p>6. On May 5, 2025, at 9:00 a.m., an observation was conducted with Certified Nurse Aide 1 (CNA 1) in the kitchen at the beverage area. CNA 1 without wearing hairnet was observed crossing the red line, entered into the kitchen making beverages.</p> <p>On May 5, 2025, at 9:09 a.m., an observation was conducted in the kitchen at the dry storage area. Maintenance staff without wearing a hairnet was observed talking with the Assistant Dietary Supervisor at the dry storage area.</p> <p>On May 6, 2025, at 3:57 p.m., an interview was conducted with Dietary Supervisor (DSS). The DSS stated non dietary staff could not pass over the red line, and enter the kitchen. Non dietary staff who need to work in the kitchen should wear a hairnet.</p> <p>A review of the facility's policy titled PERSONNEL ALLOWED IN THE FOOD AND NUTRITION SERVICES DEPARTMENT, revised date 9/14/2018, indicated, No one is allowed in the Food and Nutrition Services Department without the express authorization of the Administrator or the Director of Food and Nutrition services, except for dietary employees, Registered Dietitian and Administrator. PROCEDURE: .2. All unauthorized persons are to be discouraged from entering the Food and Nutrition Service Department.4. Everyone that enters the Food and Nutrition Services Department must .wear a hairnet.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>7. A review of the U.S. Federal and Drug Administration (FDA) Food Code 2022, 6-403.11 Designated Areas, indicated, Because street clothing and personal belongings carry contaminants, areas designated to accommodate employees' personal needs must be carefully located. Food, food equipment and utensils, clean linens, and single-service and single-use articles must not be in jeopardy of contamination from these areas.</p> <p>On May 5, 2025, at 10:13 a.m., a concurrent observation and interview was conducted with the Assistant Dietary Supervisor (ADS) at the dry storage. Dietary staff personal belongings like jackets and backpacks were observed hanging on the wall near the back entrance door. The ADS confirmed dietary staff personal belongings hanging on the wall.</p> <p>8. A review of the U.S. Federal and Drug Administration (FDA) Food Code 2022, 6-403.11 Designated Areas, the Food code indicated, Because employees could introduce pathogens to food by hand-to-mouth-to-food contact, areas designated to accommodate employees' personal needs must be carefully located. Food, food equipment and utensils, clean linens, and single-service and single-use articles must not be in jeopardy of contamination from these areas.</p> <p>On May 5, 2025, at 10:13 a.m., a concurrent observation and interview was conducted with the Assistant Dietary Supervisor (ADS) at dry storage. There was a few chairs and tables at the corner of the dry storage. The ADS stated they shared this dry storage room as a dietary staff break room.</p> <p>On May 5, 2025, at 3:54 p.m., a concurrent observation and interview was conducted with the RD at the dry storage. The RD stated the dry storage also was a break room for dietary staff. The RD stated dietary staff eat here.</p> <p>9. On May 7, 2025, at 9:27 a.m., a concurrent observation and interview was conducted with the Quality Assurance (QA) Nurse at Station 1 at the resident's refrigerator. The QA Nurse stated, all food items stored in the refrigerator need to be labeled with resident's name and received dated. There were several expired food items found in the refrigerator. Expired food items listed as the following: 7 fluid (fl) ounce (oz- a unit of measurement) Guava yogurt drink: used by date: 4/21/2025; 6.7 fl oz Strawberry smoothie used by date: 4/25/2025; 16.4 fl oz Guanabana drink: used by date: 4/2024; &amp;frac12; gallon 2 % milk: used by date: 4/9/2025; 32 fl oz Vanilla coffee creamer: used by date: 11/7/2024, 32 fl oz Hazelnut coffee creamer: used by date: 10/27/2024, 40 fl oz coffee: used by date: 9/15/2024; 32 fl oz Chocolate Oat milk: used by date: 1/5/2025; 33.8 fl oz coconut milk: used by: date 11/13/2024; There were two food items (a bowl of heavily freezer burn unable to identify food item and a bag of ice cream with 12 individual cups) found in the freezer did not have any label. The QAN stated those expired food items and heavily freezer burn food item should be discarded. The QA Nurse stated the bag of ice cream needed to be labeled with resident's name otherwise staff could not tell who it belonged to.</p> <p>A review of the facility's policy titled Food Safety and Food Storage, revised date 11/4/2024, indicated, .Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety.Policy Explanation and Compliance Guidelines: .3. Facility staff shall inspect all food, .and monitoring refrigerated food, .so it is used by its use-by date, .discarded .</p> |  |  |

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| <p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Dispose of garbage and refuse properly.</p> <p>Based on observation, interview and record review, the facility failed to dispose of garbage and refuse properly when trash were found outside on the floor surrounding the dumpsters. In addition, the lids of the dumpsters did not close properly.</p> <p>This failure had the potential to attract pests.</p> <p>Findings:</p> <p>On May 5, 2025, at 8:34 a.m., an observation was conducted outside the facility at the overflow parking lot. A green waste dumpster was observed widely open with some tree branches, and cardboard inside the dumpster. A pair of used blue glove, empty beverage cans, papers outside surrounding the dumpster.</p> <p>On May 5, 2025, at 2:11 p.m., and 4:43 p.m., an observation was conducted outside the facility at the overflow parking lot. The green waste dumpster was observed still widely open with green waste, and cardboard inside. And some trash surrounding the dumpster.</p> <p>On May 6, 2025, at 8:23 a.m., an observation was conducted outside the facility at the overflow parking lot. The green waste dumpster was observed still widely open with green waste, and cardboard inside. And some trash surrounding the dumpster.</p> <p>On May 6, 2025, at 8:35 a.m., an observation and interview was conducted with the Dietary Supervisor (DSS) at the back of the building where dumpsters were located. Five dumpsters were observed, one blue color dumpster used for recycling and another four gray color dumpsters used for trash. Three out of four gray dumpsters were observed overflowing with lids did not close properly. Trash were found outside on the floor surrounding the dumpsters. The DSS stated dumpsters' lids should close properly otherwise could attract pests.</p> <p>On May 6, 2025, at 8:45 a.m., an observation and interview was conducted with the DSS in the overflow parking lot. The green waste dumpster was observed still widely open with green waste, and cardboard inside. And some trash surrounding the dumpster. The DSS picked up trash surrounding the dumpster and closed the dumpster's lids.</p> <p>A review of the facility's policy titled Disposal of Garbage and Refuse, date revised 1/25/2024, indicated, Policy: The facility shall properly dispose of kitchen garbage and refuse. Policy Explanation and Compliance Guidelines: .7. Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insects/rodent attractions are minimized.</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 2. On May 5, 2025, at 1:57 p.m., an observation and concurrent interview was conducted with Resident 183. Resident 183 was lying in bed, awake, alert, and able to verbalize his needs. An oxygen concentrator (a device that extracts oxygen from the air and delivers a concentrated oxygen to the patient) was observed at the bedside, with oxygen nasal cannula tubing (a thin flexible tube with two prongs that delivers oxygen through the nose) connected to the concentrator. The nasal cannula tubing was observed inside the upper drawer of the resident's nightstand.</p> <p>Resident 183 stated he had not used his oxygen for two weeks. He stated he felt fine without the oxygen.</p> <p>On May 6, 2025, at 2:03 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated Resident 183 only used his oxygen as needed. She stated he went to the therapy today and was not sure if he had used his oxygen. CNA 4 acknowledged the oxygen nasal cannula tubing was coiled inside the top drawer of the nightstand. She stated the oxygen tubing should be inside the plastic bag. She stated it would be an infection control issue if the oxygen nasal cannula was not stored inside the plastic bag.</p> <p>On May 6, 2025, at 2:10 p.m., a concurrent observation and interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the oxygen tubing should not be kept inside the nightstand drawer. She stated the oxygen tubing should be inside the bag if not in use.</p> <p>On May 5, 2025, at 2:15 p.m., a concurrent observation and interview was conducted with the Infection Preventionist (IP). The IP stated the oxygen tubing should be inside the plastic bag if not in use.</p> <p>A review of Resident 183's record indicated, Resident 183 was admitted to the facility on [DATE], with diagnoses which included right leg deep vein thrombosis (DVT - a blood clot within a deep vein, usually in the leg).</p> <p>A review of the physician's order on admission indicated Resident 183 had an order for the oxygen through nasal cannula at two liters per minute as needed.</p> <p>A review of the nurse's progress notes from April 16, 2025, through May 5, 2025, indicated Resident 183 had used his oxygen on April 16, and April 17, 2025. There was no documented evidence Resident had used his oxygen after April 17, 2025.</p> <p>A review of the facility policy and procedure titled, Oxygen Administration, dated May 20, 2024, indicated, . Oxygen is administered to residents who need it, consistent with professional standards of practice .infection control measures include .keep delivery device covered in plastic bag when not in use .</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when:</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>1. For Residents 41, 73, and 115, nursing staff failed to properly clean and disinfect shared blood pressure (BP-pressure of blood in blood vessels) cuffs and a shared glucometer (blood glucose meter to measure and display the amount of sugar [glucose] in your blood) in accordance with the disposable wipe manufacturer's specified contact time (the time the resident equipment was to be in contact with the disposable wipes to kill micro-organisms). In addition, nursing staff failed to properly clean and disinfect the shared BP cuff after use in accordance with the facility's policy.</p> <p>2. For Resident 183, the oxygen nasal cannula (a device used to deliver oxygen through the nose) tubing was stored at the upper drawer of the resident's bedside nightstand.</p> <p>These failures had the potential for the vulnerable residents to be exposed to cross-contamination and the development of infections.</p> <p>Findings:</p> <p>1. During a medication pass observation on May 5, 2025, at 9:35 a.m. with Licensed Vocational Nurse (LVN) 7. LVN 7 was observed using a shared automatic wrist BP cuff to measure Resident 115's BP. LVN 7 was observed wiping the shared automatic wrist BP cuff with a Sani-Cloth disposable wipe. LVN 7 said, Need to leave [BP cuff] to dry for 2 minutes. LVN 7 did not disinfect the automatic wrist BP cuff in accordance with the manufacturer's specified contact time.</p> <p>During a medication pass observation on May 5, 2025, at 9:55 a.m., with LVN 8. LVN 8 was observed using a shared glucometer to measure Resident 41's concentration of blood glucose. LVN 8 was observed wiping the glucometer with a Sani-Cloth disposable wipe and did not disinfect the glucometer in accordance with the manufacturer specified contact time.</p> <p>During the same medication pass observation, LVN 8 was observed using a shared automatic BP cuff to measure Resident 41's BP. After obtaining Resident 41's BP reading, LVN 8 removed the automatic BP cuff from Resident 41's right arm and placed the automatic BP cuff machine on top of the medication cart. LVN 8 was not observed to have disinfected the automatic BP cuff machine after it was used on Resident 41.</p> <p>During another medication pass observation on May 5, 2025, at 10:20 a.m., with LVN 8, LVN 8 retrieved the same automatic BP cuff machine (previously used on Resident 41) from on top of the medication cart and proceeded to Resident 73's room. LVN 8 applied the automatic BP cuff on Resident 73's left arm. LVN 8 was not observed to have disinfected the automatic BP cuff machine before it was used on Resident 73.</p> <p>During an interview on May 5, 2025, at 12:03 p.m., with LVN 7, LVN 7 stated nursing staff should wipe shared resident care equipment to disinfect after each use and let the equipment sit to dry for two minutes.</p> <p>During an interview on May 5, 2025, at 12:12 p.m., with LVN 9, LVN 9 stated nursing staff should use Sani-Cloth disposable wipes to disinfect shared resident care equipment, such as BP cuffs and glucometers, after each use. LVN 9 stated nursing staff should let the equipment dry after wiping to ensure it had been disinfected.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>During an interview on May 5, 2025, at 12:19 p.m., with the Infection Preventionist (IP), the IP stated nursing staff were expected to clean and disinfect all shared resident care equipment after use and before the next resident with Sani-Cloth disposable wipes. The IP stated nursing staff should wipe the equipment and keep equipment wet for two (2) minutes to achieve contact time when they wiped shared resident care equipment in accordance with the manufacturer's instructions. The IP stated it was important to follow the manufacturer's instructions to kill all germs.</p> <p>During an interview on May 5, 2025, at 2:52 p.m., with the Director of Nursing (DON), the DON stated nursing staff were expected to clean and disinfect all shared resident care equipment after each use in accordance with the policy and to follow the Sani-Cloth manufacturer's instructions for contact time to achieve proper kill time of organisms. The DON stated it was important to follow infection control policy and manufacturer's instructions to prevent the spread of infections.</p> <p>A review of the facility's policy and procedure (P&amp;P) titled, Cleaning and Disinfection of Resident-Care Equipment, revised on December 19, 2022, indicated, Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC (Centers for Disease Control and Prevention- a nationally recognized disease control and prevention organization) recommendations in order to break the chain of infection .Reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include . blood pressure cuffs .Multiple-resident use equipment shall be cleaned and disinfected after each use.</p> <p>A review of the manufacturer's instructions for contact time for the Sani-Wipes provided by the facility, indicated, Contact time .thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry.</p> |  |  |

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| <p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>                                   | <p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure that bedrooms measured at least 80 square (sq) feet (ft) per resident, in bedrooms occupied by multiple residents (Rooms 101, 106, 107, 112, 119, 121, 123, and 125).</p> <p>Findings:</p> <p>On May 5, 2025, during the initial tour of the facility, at 9:03 a.m., no residents reported any concern regarding the size of their rooms.</p> <p>Eight bedrooms occupied by multiple residents did not measure at least 80 sq. ft. per resident as required:</p> <ul style="list-style-type: none"> <li>- rooms [ROOM NUMBERS]: two residents; 156 total sq. ft.; 78 sq. ft. per resident;</li> <li>- rooms [ROOM NUMBERS]: three residents; 208 total sq. ft.; 69 sq. ft. per resident;</li> <li>- room [ROOM NUMBER]: two residents; 143 total sq. ft.; 71.5 sq. ft. per resident;</li> <li>- room [ROOM NUMBER]: four residents; 312 total sq. ft.; 78 sq. ft. per resident; and</li> <li>- rooms [ROOM NUMBERS]: two residents; 154 total sq. ft.; 77 sq. ft. per resident.</li> </ul> <p>On May 9, 2025, at 10:18 a.m., Resident 51 was observed entering her room in a wheelchair.</p> <p>In a concurrent interview, Resident 51 stated she had enough space and was able to move around the room in a wheelchair without any problem.</p> <p>On May 9, 2025, at 10:27 a.m., Resident 281 was observed in bed, awake and alert.</p> <p>In a concurrent interview, Resident 281 stated staff helped her to transfer from bed to chair and back with no issues. She also stated she was able to move in and out of the room with no issues.</p> <p>On May 9, 2025, at 10:43 a.m., Certified Nursing Assistant (CNA) 5, was interviewed. She stated she helped another staff to transfer a resident from bed to the Geri chair (Geriatric chair - a type of chair that provides support and comfort in a recliner) using the Hoyer lift (a device used to help caregivers safely lift and transfer patients who have mobility challenges) in room [ROOM NUMBER]. She stated, most of the time, rooms with small spaces were not filled so there would be more room to move around.</p> <p>On May 9, 2025, at 10:49 a.m., CNA 6 was interviewed. CNA 6 stated most of the time, room [ROOM NUMBER] was not full, or the other residents in the room were able to move in and out of the bed freely.</p> <p>(continued on next page)</p> |  |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055409  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/09/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Community Care and Rehabilitation Center   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>                                   | <p>On May 9, 2025, at 3:44 p.m., the Director of Nursing (DON) was interviewed. He stated for the rooms with waivers, the facility made sure the staff had enough space to work, and the residents were comfortable. He stated no residents on bariatric beds (wider and longer than a standard bed) were placed in the rooms with waivers. He also stated if a resident had a complaint or issue with the space and requested for a room change, the resident will be accommodated. He stated there was no complaint from the residents placed in the rooms with waivers.</p> <p>During the entire survey dates, there was no negative impact observed on the health and safety of the residents placed in the rooms with waivers. There were no complaints received from the residents regarding space.</p> <p>A review of the facility policy and procedure titled, Resident Rooms, revised December 2, 2024, indicated, . Resident bedrooms will measure at least 80 square feet per resident in multiple resident bedrooms and at least 100 square feet in single resident bedroom .</p> |  |  |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the call light system (a communication system that allow the resident to call for staff assistance) located in Station 2 had an adequate audible sound.</p> <p>This failure had the potential for the residents located in Station 2 not to receive assistance from the staff in a timely manner.</p> <p>Findings:</p> <p>On May 6, 2025, the Resident Council (a group of residents in the facility that meets regularly to address issues and concerns to improve resident satisfaction) meeting minutes for February 2025, March 2025, and April 2025, were reviewed. The minutes for March and April 2025, indicated the call lights were not answered in a timely manner.</p> <p>On March 6, 2025, at 2:03 p.m., the Resident Council meeting was conducted with six residents present. During the Resident Council meeting, the call-light response time for the evening shift in Station 2 was still a concern. Resident 73 stated he would get out of bed, walk to the door and yell out for attention.</p> <p>On May 8, 2025, at 3:59 p.m., while standing in front of Station 2, the call light panel located on the wall of Station 2 was observed with the light on for room [ROOM NUMBER]. The call light panel did not have an audible sound heard while the light was on in room [ROOM NUMBER]. There were two Licensed Vocational Nurses (LVN) at the nurse's station with their backs turned away from the call light panel.</p> <p>During a concurrent interview with LVN 3, she stated the call light system had a faint sound. She stated the sound was not loud enough because it was noisy at the nurse's station. LVN 3 stated the call-light sound was not audible outside the nurse's station.</p> <p>On May 8, 2025, at 4:09 p.m., a concurrent observation and interview was conducted with the maintenance staff (MS). The call light panels were tested in Stations 1, 2, and 3. The MS stated the call light system panel in Station 2 had a very faint sound and was not audible outside the nurse's station compared to Stations 1 and 3.</p> <p>On May 8, 2025, at 4:36 p.m., the Maintenance Director (MD) was interviewed. He stated he did not receive any order or report that the call light in Station 2 was not fully functional. He stated he would routinely check the call light system and would made sure the light will turn on in the resident's room and in the call light system panel located at the nurse's station. He stated he did not pay attention to the sound of the call light system.</p> <p>On May 8, 2025, at 5:25 p.m., the Administrator was interviewed. He stated he was aware of the issue of the call light response time but he was not aware there was an issue with the call light system.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A review of the facility policy and procedure titled, Preventative Maintenance Program, revised December 12, 2022, indicated, .A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional .environment for residents .The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the .equipments are maintained in a safe and operable manner .</p> |  |  |