STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055474	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodcrest Post Acute & Rehabilitation	8133 Magnolia Avenue Riverside, CA 92504

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on interview and record review, the facility failed to ensure an adequate preparation and orientation for a safe and orderly discharge was afforded to one of two sampled residents (Resident 2) and her family member. Resident 2 was living with a family member, who was not provided adequate preparation and orientation prior to the planned discharge. This failure had the potential for Resident 2 to have an increased risk of accidents and rehospitalization if she was discharged from the facility. Findings: On April 23, 2024, at 10:45 a.m., an unannounced visit was conducted at the facility to investigate an issue on discharge and transfer. On April 23, 2024, at 10:53 a.m., a concurrent interview and observation was conducted with Resident 1. Resident 1 was sitting on her wheelchair, watching television, alert, and conversant. Resident 1 stated she told the staff she wanted to go home by the end of February 2024. Resident 1 stated she was not able to go home last February 29, 2024, because her family member was not ready for her. Resident 1 stated she was also given a notice in February 2024, indicating that she had 30 days until she can leave the facility because she owed them money. Resident 1 stated she did not know if her family members were aware of the notice. On April 26, 2024, at 10:48 a.m., an interview was conducted with the Certified Nurse Assistant (CNA). The CNA stated he was always assigned to Resident 1. The CNA stated Resident 1 was capable of going to the restroom by herself, but most of the time required assistance with personal hygiene. The CNA stated Resident 1 can transfer from bed to chair and vice versa by herself. The CNA stated Resident 1 can ambulate, but her balance was not good. Furthermore, the CNA stated it would be better for Resident 1 to have assistance if she was to be discharged home. A review of Resident 1 ' s records indicated she was admitted to the facility on [DATE], with diagnoses which included encephalopathy (damage or disease that affects the brain), cerebrovascular accident (stroke) with left sided weakness, type 2 diabetes (high blood sugar) and chronic kidney disease (kidneys have been damaged overtime). A review of Resident 1 ' s History and Physical, dated May 8, 2023, indicated she has the capacity to understand, make decisions, and the surrogate decision maker was one of her family members (FM). (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Minimum Data Set (MDS - an assessment tool) dated February 14, 2024, indicated Resident 1 required supervision with eating, oral hygiene, toileting hygiene, and shower. The MDS indicated Resident 1 required partial/moderate assistance (helper lifts, holds trunk or limbs but provides less than half the effort) with upper body dressing, hygiene and rolling left and right. In addition, the MDS indicated Resident 1 required substantial/maximal assistance (helper lifts, holds trunk or limbs but provides more than half the effort) with sit to lying. A review of Resident 1 ' s care plan dated May 6, 2023, indicated Resident 1 prefers to discharge to home where she lives with her FM, and interventions included review and discuss discharge plan with resident/family as appropriate. A review of records indicated Resident 1 was issued a notice of transfer / discharge on February 9, 2024, due to non-payment of her stay in the facility. The notice was effective on March 10, 2024, and the notice indicated Resident 1 will be discharged to her home. The notice indicated Resident 1 refused to sign. Further review of records indicated no documentation that Resident 1 ' s FM was notified on February 9, 2024. In addition, there was no documented evidence of other discharge preparations with Resident 1 and her FM between February 9, 2024, and February 27, 2024. On April 26, 2024, at 11:37 am, a concurrent interview with the SSD and record review of Resident 1 ' s record was conducted. The SSD stated Resident 1 was issued a notice of transfer/discharge on February 9, 2024, due to non-payment and the resident requested to go home at the end of February 2024. The SSD stated Resident 1 ' s Physician Assistant was aware and there was a physician ' s order relative to the discharge. The SSD stated the resident was self-responsible. The SSD stated she received a call from Resident 1 ' s FM on February 27, 2024, to discuss the discharge plan. The SSD stated Resident 1 ' s FM requested for more time to make arrangements at Resident 1 ' s home. The SSD stated Resident 1's post discharge plan was provided by informing her of the personalized resources on March 8, 2024, set up home health, transportation, and pharmacy referrals, as they were covered by her insurance. However, other services required private pay, and Resident 1 needed to agree to the expenses. The SSD stated the three-day period between March 8 to 10, 2024, was sufficient for Resident 1 to arrange private caregivers and other options she would like to have. Resident 1 was not discharged from the facility on March 10, 2024, because her FM filed an appeal on March 9, 2024. The SSD stated if Resident 1 ' s FM did not appeal, Resident 1 would still have been discharged to her home. The SSD stated Resident 1 can manage toileting and transferring on her own and had been provided with ample information during her stay. On April 26, 2024, at 1:52 p.m., a concurrent interview with Licensed Vocational Nurse (LVN) 2 and record review of Resident 1 ' s consent forms was conducted. LVN 2 stated that Resident 3 ' s FM signed the medical treatment, bed hold notification, pneumonia vaccine consent forms, physician orders for life sustaining treatment and informed consent for psychotropics and that the FM was the responsible party. LVN 2 further stated, Resident 3 ' s FM should be aware of Resident 3 ' s plan of care because she signed the forms. A review of the physician order dated February 29, 2024, indicated .Discharge resident to home on 3/10/2024 (March 10, 2024) per resident request with meds, including narcotics, controlled substances home health, PT eval, OT eval, wound care . (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 26 at 2:11 p.m., an interview was conducted with the Administrator (ADM). The ADM stated preparing the residents for discharge included multiple things such as issuing a notice, finding out the resident ' s needs, consultation with therapy, ensuring residents ' equipment will be at home, provide resources based on the clinical need and get physician ' s orders. The ADM stated Resident 1 was self-responsible. The ADM stated the staff asked Resident 1 if they can share information with her FM and she said no. The ADM further stated they have to respect her wishes. A review of the facility ' s policy and procedure titled, Transfer or Discharge, Preparing, a Resident for, dated December 2023, was reviewed. The policy indicated .residents will be prepared in advance for discharge . a post discharge plan is developed for each resident prior to his or her transfer or discharge .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on observation, interview, and record review, the facility failed to ensure the safety of one of three sampled residents (Resident 3) reviewed for falls, when the facility failed to repair a loose toilet seat being used by Resident 3 after it was reported to staff as needing repair on April 2, 2024. This failure resulted in Resident 3 falling off the loose toilet seat and sustaining a broken hip that required surgical repair at the general acute care hospital (GACH). Findings: On April 23, 2024, at 12:37 p.m., a concurrent observation and interview was conducted with Resident 3. Resident 3 was in his room, lying in bed, alert and conversant. Resident 3 stated, he fell in the restroom on April 3, 2024, at approximately 2:30 p.m. Resident 3 stated he was going to use the toilet, and as he was sitting down, he placed one of his hands on the toilet seat and the toilet seat moved sideways which caused him to fall to the ground. Resident 3 stated he had spoken to the Social Service Assistant (SSA) about the loose toilet seat the day before he fell (April 2, 2024). Resident 3 stated he was assessed by a Registered Nurse, and two Licensed Vocational Nurses (LVNs) helped him from the ground to the bed, and then he was transferred to the hospital. Resident 3 stated he had just returned from the hospital after having surgery on his left hip. Resident 3 stated his goal was to be able to walk again at least with a walker. Resident 3 stated he was in pain, had lost his self-respect because he now had to use a commode (portable toilet) and he needed assistance with toileting. A review of Resident 3 ' s medical record was conducted. Resident 3 was initially admitted to the facility on [DATE]. A review of Resident 3 ' s Minimum Data Assessment (MDS- an assessment tool) dated February 10, 2024, indicated Resident 3 ' s cognition (the ability to make decision and produce appropriate response) was intact, and Resident 3 was independent with toilet transfer (the ability to get on and off a toilet or commode - a portable toilet) and independent with walking 150 feet. The MDS further indicated that Resident 3 had diagnoses which included hypertension (high blood pressure) end stage renal disease (a permanent kidney failure that requires a regular course of dialysis - a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) and stroke (loss of blood flow to a part of the brain). A review of Resident 3 ' s care plan dated June 21, 2023, indicated Resident 3 .was at risk for falls and interventions included .maintain safe environment . A review of Resident 3 ' s Daily Nurses Note dated April 3, 2024, indicated Resident 3 .was trying to use the toilet but the toiled (sic) lid (sic) was lose (sic) and when he sit (sic) the toilet the sit (sic) moved and he ended on the floor .pt complain (sic) of pain 10/10 (a score of 0 means no pain, and 10 means the worst pain) . 911 (emergency telephone number) was called .pt was taking (sic) to hospital at 3:25 p.m. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 3's GACH notes titled, Trauma - History and Physical, dated April 3, 2024, indicated, [AGE] year-old male .presents from skilled nursing facility after ground level fall early this morning . trauma surgery consulted for left hip fracture .he notes that his toilet seat has been loose for several days and had not been fixed. He sat on the toilet seat, and it slipped, and he fell on to his left side .extremities . LLE (left lower extremity) shortened and externally rotated .ROM (range of motion) limited due to pain . Further review of Resident 3 ' s medical record indicated Resident 3 was readmitted to the facility on [DATE], with diagnoses which included fracture of the left femoral neck (a break in the left hip bone), status post left hemiarthroplasty (received a partial left hip replacement), and history of stroke with left hemiparesis (left sided weakness). A review of Resident 3 ' s IDT (interdisciplinary team - group of health care professionals with various areas of expertise who work together) - Incident Review dated April 10, 2024, indicated that Resident 3 had a fall incident on April 3, 2024, at 3:00 p.m. The IDT Incident Review indicated description of incident .denies hit his head. pt (patient) states was trying to use the toilet and the seat was lose (sic) which lid (sic) to fall . The IDT Incident Review further indicated .contributing factors/root cause analysis (the process of discovering the root cause of a problem) were diagnosis/comorbidities (two or more diseases present at once) and environmental . A review of Resident ' s 3 PT (Physical Therapy) Evaluation & (and) Plan of Treatment, dated April 11, 2024, indicated .Pt has significant deficits in functional mobility due to recent L (left) hip arthroplasty (surgical reconstruction or replacement of a joint) . Pt requires increased time to perform tasks due to pain and weakness .Pt is currently functioning below previous baseline and requires skilled PT intervention to restore safe functional mobility . On April 23, 2024, at 1:12 p.m., an interview was conducted with LVN 1. LVN 1 stated on April 3, 2024, during the change of shift between 7-3 (am) and 3-11 (pm), she was rounding (visiting the residents) with another LVN, when they found Resident 3 on the restroom floor inside his room. LVN 1 stated Resident 3 stated the toilet seat went sideways when he sat down and caused him to fall. LVN 1 stated she had not received any reports from Resident 3 or any other residents about a loose toilet seat. LVN 1 stated if Resident 3 had told her, she would have reported it to the maintenance department right away. On April 23, 2024, at 1:20 p.m., an interview with the Maintenance Assistant (MA) was conducted. The MA stated there were maintenance logs at each station where staff can record broken equipment. The MA stated he reviewed the maintenance logs every day, in the morning, to check what needed to be fixed. The MA stated he was informed about the loose toilet in Resident 3's restroom on April 4, 2024 (the day after Resident 3 ' s fall). A review of the facility ' s maintenance logs for April 2024, at Station 1, 2 and 3 was conducted. There was no information written on the maintenance logs for April 1, 2 and 3, 2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On April 23, 2024, at 2:06 p.m., an interview was conducted with the SSA. The SSA stated if there was broken facility equipment, she would write it on the maintenance log. The SSA stated she was not initially aware that there were maintenance logs at each nurse ' s station. The SSA stated Resident 3 told her about the loose toilet seat the day before he was transferred to the hospital (April 2, 2024). The SSA stated she reported it to her supervisor, the Social Service Designee (SSD). The SSA stated the SSD told her that there were maintenance logs at each nurse ' s station. The SSA stated she was able to locate the maintenance logs, but she did not record the loose toilet seat in Resident 3 ' s restroom. On April 23, 2024, at 3:20 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated there were maintenance logs in each nurse ' s station. The DON stated the staff can record on the logs what needs to be fixed. The DON stated the maintenance department checked the logs every day and the maintenance director attended the morning meeting. The DON stated Resident 3 fell on [DATE], and he mentioned that the toilet seat was loose in his restroom. The DON stated the maintenance department was notified right away and the loose toilet seat was fixed the same day. The DON stated she was not aware that the SSA knew about the loose toilet seat in Resident 3 ' s restroom before Resident 3 fell . The DON stated the SSA should have written it down on the maintenance log and alerted the maintenance staff verbally when she knew about it. The DON stated a loose toilet seat was an accident hazard. On April 23, 2024, at 4:43 p.m., an interview with the Administrator (ADM) was conducted. The ADM stated when staff noticed broken facility equipment or a loose toilet seat, they should record it on the maintenance log. A review of the facility ' s policy and procedure titled, Safety and Supervision of Residents dated November 2023 was reviewed. The policy indicated, .resident safety and supervision and assistance to prevent accidents are facility-wide priorities .employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents .