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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055474	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on observation, interview and record review, the facility failed to ensure, for one of three residents, Resident 2, had the call light within her reach. This failure had the potential to result for Resident 2 to not be able to call for help. Findings: On June 24 and 25, 2024, unannounced visits were conducted at the facility. On June 24, 2024, at 2:25 p.m., during a concurrent observation and interview with Resident 2, Resident 2 was lying in bed and alert. Resident 2 was mouthing words and her responses were unclear. Resident 2 was observed moving her left hand towards her right side. Resident 1 nodded her head up and down when asked if she needed help. Resident 2 ' s call light was found hanging on the TV mount of her roommate by Resident 2 ' s right hand-side. On June 24, 2024, at 2:27 p.m., during an interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 2 ' s call light was not within her reach. CNA 1 stated, Resident 2 will not be able to ask for help if the call light was not within her reach. CNA 1 further stated, Resident 2 ' s call light should be within her reach. A review of Resident 2 ' s medical record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included stroke (a condition when blood flow to the brain is blocked) with right sided weakness and aphasia (loss of ability to understand or express speech). Resident 2 ' s care plan indicated Resident 2 had a self-care deficit related to her inability to independently perform activities of daily living and interventions included .call light within reach . On June 25, 2024, at 10:18 a.m., during a follow up interview with CNA 1, CNA 1 stated Resident 2 required substantial assistance (helper does more than half the effort) with activities of daily living except for eating. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 25, 2024, at 10:48 a.m., during an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 was able to use the call light. LVN 1 stated that Resident 2 ' s call light should always be within her reach. On June 25, 2024 at 3:30 p.m., during an interview with the Director of Nursing (DON), the DON stated call lights should be within reach of the residents. The DON further stated when a call light is not within reach of a resident, there would be a delay in responding to the care and the resident wouldn ' t be able to call for help. A review of the facility ' s policy titled, Answering Call Lights, dated March 2021 indicated .when the resident is in bed . be sure the call light is within easy reach of the resident . On June 25, 2024 at 6:29 p.m., during a follow up interview with the DON with a concurrent record review of their Answering Call Lights policy, the DON stated the policy was not followed when Resident 2 ' s call light was not within her reach.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on interview and record review, the facility failed to ensure, for one of two residents, Resident 1, that the responsible party (RP) was notified when Resident 1 had a change of condition (COC) and was transferred out to a general acute care hospital (GACH). This failure resulted in Resident 1 ' s RP to not be aware of Resident 1 ' s health condition. Findings: On June 24 and 25, 2024, unannounced visits were conducted at the facility. On June 25, 2024, at 10:48 a.m., during an interview with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the doctor, family members or responsible party were notified when a resident had a COC. On June 25, 2024, at 3:30 p.m., during an interview with the Director of Nursing (DON), the DON stated the staff should notify the doctor and RP when a resident had a COC. The DON stated the RP should be notified as well when a resident was sent out to the hospital. A review of Resident 1 ' s Admission Record indicated Resident 1 was initially admitted to the facility on [DATE], and (name of family member) was the responsible party. A review of Resident 1 ' s History and Physical Examination (H&P) dated July 10, 2023, indicated Resident 1 had diagnoses which included supraventricular tachycardia (irregular heartbeat) and hypertension (high blood pressure). The H&P further indicated Resident 1 .can make needs known but cannot make medical decisions . A review of Resident 1 ' s Daily Nurses Note, dated July 15, 2023, at 8:50 p.m. indicated, .Pt back from ER (emergency room) in stable condition . no c/o (complaints of) chest pain at this time. RN (Registered Nurse) contacted MD (Medical Doctor) to notify that resident is back from ER visit . A review of Resident 1 ' s ER Patient Admission Record, indicated Resident 1 was admitted at (name of GACH) on July 15, 2023, at 11:03 a.m., for chest pain. There was no documented evidence in Resident 1's chart that Resident 1 was transferred out to a GACH for chest pain on July 15, 2023, and that the RP was notified. On June 25, 2024, at 6:10 p.m., a concurrent interview with Medical Records staff (MR) and record review of Resident 1 ' s record was conducted. The MR stated there was no documentation in Resident 1 ' s chart that she left the faciity on [DATE]. The MR further stated there were no other documentation that Resident 1 ' s RP was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s policy and procedure titled, Changes of Condition, dated December 2023, indicated .a nurse will notify the resident ' s representative when . there is a significant change in the resident ' s physical, mental or psychosocial status . it is necessary to transfer the resident to a hospital/treatment center . the nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status . On June 25, 2024, at 6:29 p.m., during a follow up interview with the Director of Nursing (DON) and record review of Resident 1 ' s record, the DON stated Resident 1 ' s RP should have been notified when she was transferred out of the hospital. The DON further stated that the facility did not follow their policy.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on interview and record review, the facility failed to ensure, for one of one resident, Resident 1, that a physician ' s order for physical therapy was communicated with the hospice (care that focuses on the comfort and quality of life rather than curing a disease) provider. This failure resulted for Resident 1 not receiving physical therapy as ordered by the physician. In addition, this failure resulted for the hospice provider to not be fully aware of Resident 1 ' s overall condition. Findings: On June 24 and 25, 2024, unannounced visits were conducted at the facility. On June 24, 2024, at 2:01 p.m., during a concurrent observation and interview with Resident 1, Resident 1 was observed in her room, lying in bed, alert and conversant. Resident 1 stated she required assistance with activities of daily living. A review of Resident 1 ' s medical record was conducted. Resident 1 was initially admitted to the facility on [DATE], with diagnoses which included supraventricular tachycardia (irregular heartbeat) and rheumatoid arthritis (disorder that affects the joints). A review of Resident 1 ' s physician orders, indicated she was under hospice care on November 29, 2023. A review of Resident 1 ' s Daily Progress Notes, dated December 5, 2023, indicated Resident 1 went to an orthopedic appointment and returned to the facility with an order of PT (Physical therapy) for gait training/ROM (range of motion) 2x 6 weeks (sic). There was no documented evidence that the physician ' s order for PT on December 5, 2023 was communicated to the hospice provider. On June 25, 2024, at 1:36 p.m., an interview with the Director of Rehabilitation (DOR) and a concurrent record review of Resident 1 ' s record was conducted. The DOR stated nurses communicated with him when there was any physician ' s order for rehabilitation therapy. The DOR stated Resident 1 received physical and occupational therapies on the following dates: July 9 to 28, 2023, August 20 to 31, 2023 and September 11 to September 27, 2023. On June 25, 2024, at 2:49 p.m., a follow up interview with the DOR and a concurrent record review of Resident 1 ' s record was conducted. The DOR stated there was a physician ' s order for physical therapy two times per week for six weeks for Resident 1 on December 5, 2023. The DOR stated the physician's order was not communicated with him. The DOR stated the physician's order should have been communicated with him. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 25, 2024, at 3:30 p.m., during a concurrent interview with the Director of Nursing and record review of Resident 1 ' s medical record, the DON stated, Resident 1 was under hospice care. The DON stated hospice managed everything for residents who were under hospice care. The DON stated the hospice provider must have declined the physical therapy for Resident 1. A review of the facility ' s policy and procedure titled, Hospice Program, dated July 2017, was reviewed. The policy indicated .in general, it it ' s the responsibility of the facility to meet the president ' s personal care and nursing needs in coordination with the hospice representative . these responsibilities include the following: administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care . communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident and met 24 hours per day . On June 25, 2024, at 6:29 p.m., during a follow up interview with the DON and a concurrent record review of their Hospice Program policy, the DON stated the physician ' s order for physical therapy on December 5, 2023, should have been communicated to the hospice provider.