

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 11/13/2024
NAME OF PROVIDER OR SUPPLIER Woodcrest Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview and record review, the facility failed to answer the call light within a reasonable time for three of three residents reviewed (Residents 5, 6, and 7).</p> <p>This failure had the potential to result in needs not to be met efficiently for Residents 5, 6, and 7.</p> <p>Findings:</p> <p>1. On October 13, 2024, Resident 5 ' s electronic record was reviewed. Resident 5 was admitted on [DATE], with diagnoses which included osteoarthritis- right hip (type of arthritis when the cartilage that lines the joint is worn down), muscle wasting and atrophy (loss of muscle tissue and strength) and history of falling.</p> <p>On November 13, 2024, at 3:36 p.m., a telephone interview was conducted with Resident 5's family representative (FR 3). The FR stated Resident 5 called the family some weeks ago and stated she (Resident 5) pushed her call light button for assistance to the restroom and no one responded.</p> <p>2. On November 13, 2024, Resident 6 ' s electronic record was reviewed. Resident 6 was admitted on [DATE], with diagnoses which included fracture (a break in a bone) of left lower leg, hypertension (high blood pressure), and difficulty walking. Resident 6 was awake, alert, and oriented and able to make decision for himself.</p> <p>On November 13, 2024, at 2:51 p.m., while in hallway of station 2, observe call lights activated in Resident 6's room and Resident 7's room. Observed several staff members walking up and down the hall, and no one checked with the residents for their needs.</p> <p>On November 13, 2024, at 3:10 p.m., a concurrent observation and interview with Resident 6 was conducted. Observed Resident 6's call light was on, with Resident 6 lying in bed, wearing a fall risk bracelet with a cast to his left lower leg. Resident 6 stated he pushed his call light over 10 minutes ago and no one has come in. Resident 6 stated this morning he waited over an hour for someone to empty his urinal; and the resident stated he found it upsetting to wait.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. On November 13, 2024, Resident 8 ' s electronic record was reviewed. Resident 7 was admitted on [DATE], with diagnoses which included metabolic encephalopathy (chemical imbalance of the blood that affects the brain), osteoarthritis (type of arthritis when the cartilage that lines the joint is worn down) of both knees, and hypertension (high blood pressure). Resident 7 had a Brief Interview for Mental Status (BIMs) of 7 which indicated moderate cognitive impairment.</p> <p>On November 13, 2024, a concurrent observation and interview with Resident 7 was conducted. Observed Resident 7 ' s call light was on, and Resident 7 was awake, lying in his bed. The resident stated he needed to be changed, and he activated his call light over 15 minutes ago and no one has answered. Resident 7 stated did not complain to anyone, since nothing will be done.</p> <p>On November 13, 2024, at 3:26 p.m. during an interview, Certified Nursing Assistant (CNA) 1 stated she was not the nurse for Resident 7. CNA 1 stated the facility ' s policy is to answer the call lights right away. CNA 1 further stated everyone is responsible for answering the call lights, even if the residents were not assigned to them.</p> <p>On November 13, 2024, at 4:14 p.m. during an interview, CNA 2 stated the facility ' s process for answering call lights is to answer as soon as possible and it does not matter if you are not assigned to the resident. CNA 2 stated she had an in-service for call lights often this year, because of the complaints about the call lights. CNA 2 further stated the biggest complaint she gets from residents was, they feel no one is there for them.</p> <p>On November 13, 2024, at 4:41 p.m. during an interview with the Director of Nursing (DON), she stated her expectation is that call lights should be within reach of the residents and the staff should answer the call lights as soon as possible. The DON stated everyone is responsible for answering the call lights to ensure residents' needs are met.</p> <p>A review of the facility policy and procedure titled, Answering the Call Light, dated March 2021, indicated, The purpose of this procedure is to ensure timely response to the resident ' s requests and needs .</p>		