| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055474 | A. Building<br>B. Wing | 11/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Woodcrest Post Acute & Rehabilitation | 8133 Magnolia Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000<br><br>Based on observation, interview, and record review, the facility failed to treat with respect and dignity, for two of five residents (Residents A and B), when the facility left a deceased resident (Resident C) in the same room with Residents A and B for approximately 12 hours, before removing the body.<br><br>This failure resulted in Residents A and B ' s experiencing negative psychosocial (a person ' s well-being-mental, emotional, social, and spiritual health) outcomes.<br><br>Findings:<br><br>On [DATE], at 9:05 a.m., an unannounced visit to the facility was conducted to investigate a complaint of resident rights.<br><br>On [DATE], at 9:50 a.m., Resident C's bed was observed to be not made up and the sheets were dirty. Two wheelchair footrests were observed on top of the bed.<br><br>On [DATE], at 10:00 a.m., an interview was conducted with Resident B. Resident B stated Resident C passed away early in the morning of [DATE], and the Resident C's body was left in the room until 7:30 p.m., that night. Resident B stated, it was a very traumatic day, things should have been handled differently, anyone who came in the room, did not acknowledge us (Resident A and B), the staff went to Resident C ' s bed, and then would walk out of the room. Resident B stated her family came in to visit her during dinner time and asked the staff if Residents A and B could eat our meals in another room, because Resident C's body was starting to smell. Resident B stated she did not eat very much as it was difficult to eat with a dead body next to her. Resident B stated the employees kept walking in and out of the room, not knocking on the door, it was disrespectful. Resident B stated all she could think about was she did not want to end up like Resident C, left dead in a room, no dignity.<br><br>On [DATE], a review of Resident C ' s medical records was conducted. Resident C was admitted to the facility on [DATE], with diagnoses which included kidney disease and high blood pressure.<br><br>(continued on next page) |



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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of Resident C ' s Daily Nurses Note, dated [DATE], at 12 p.m., indicated, . At 7:28 a.m. CNA (certified Nursing Assistant) went into provide care for resident and she was unresponsive .CPR (cardiopulmonary resuscitation- an emergency procedure that involves chest compressions and rescue breathing) was started .fire department came in at 7:40 a.m. and took over . pronounce dead at 8:57 a.m.<br><br>A review of Resident C ' s Social Service Note, dated [DATE], at 7:30 p.m., indicated, .residents remains (a dead body) picked up by (name of mortuary) .<br><br>On [DATE], a review of Resident B ' s medical records was conducted. Resident B was admitted to the facility on [DATE], with diagnoses which included, fracture of the pubis (broken pelvis) and respiratory failure (difficulty with breathing). Resident B ' s history and physical, dated [DATE], indicated Resident B has the capacity to understand and make decisions.<br><br>A review of Resident B ' s Trauma Evaluation, dated [DATE], at 9:53 a.m., indicated, .identify the worst event .witnessed roommate passing away and time it took for next steps after death .how much were you bothered by the event .quite a bit .feeling or acting as if the stressful experience was actually happening again .a little bit .fell ing very upset .quite a bit .having strong physical reactions .a little bit .avoiding external reminders . quite a bit .blaming yourself or someone else for the stressful experience .moderately .feeling jumpy or easily startled .a little bit .trouble falling or staying asleep .quite a bit .<br><br>A review of Resident B ' s Social Service Notes, dated [DATE], at 12:12 p.m., indicated, .discussed recent passing of roommate and how resident is coping. Resident verbalized she is having a hard time. SSD (Social Service Director) offered to make a referral to psychology so that resident can discuss and process her feelings .resident agreeable. SSD offered room change, resident was interested .<br><br>On [DATE], at 10:30 a.m., the Licensed Vocational Nurse (LVN) was interviewed. The LVN stated she was the nurse assigned to Resident C when she passed away on the morning of [DATE]. The LVN was observed to enter Resident C's room and stated the resident's bed was not cleaned since Resident C had passed away yesterday. The LVN stated Resident C's bed should have cleaned up after the resident was picked up by the mortuary.<br><br>On [DATE], at 10:40 a.m., the Administrator (ADM) was interviewed. The ADM stated a resident's dead body would be removed from the room as soon as possible after the family arrives and given time to [NAME].<br><br>On [DATE], at 1:15 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated she followed up with Residents A and B, regarding the death of Resident C, and offered them both room changes. The SSD stated normally the facility would contact the family after a death, and if the family does not have a mortuary picked out, we can give them information, to make arrangements and to have the body be picked up as soon as possible. The SSD stated she understands there was a smell from the Resident C ' s body being left in the room for so long, the staff should have offered a room change to Residents A and B.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE], at 1:40 p.m., an interview with the Staffing Coordinator (SC) was conducted. The SC stated he had been a Certified Nursing Assistant (CNA) and when a resident had died , and there are roommates, we may take the resident who had died out of the room, or we take the roommate(s) out. The SC stated once a resident had died , it would take about two or three hours until the mortuary picks up the body. The SC stated 12 hours was an unusual amount of time to have a resident who had died , remain in the facility, the roommates should not have to stay in the room with a dead resident.<br><br>On [DATE], at 2:10 p.m., an interview was conducted with the Licensed Vocational Nurse (LVN). The LVN stated it was not discussed with her about moving Resident C out of the room, after she died or Resident A and B out of the room. The LVN stated before leaving at 3:30 p.m., she understood Resident C ' s family was making arrangements, and the Registered Nurse (RN) was going to call and have the mortuary pick up the body. The LVN stated the dead body was to be removed from the facility within two hours after a resident ' s death. Resident A or B did not say anything to her, about moving rooms, and the Registered Nurse said she will deal with it.<br><br>On [DATE], at 2:25 p.m., an interview was conducted with the CNA. The CNA stated she felt bad for Residents A and B and thought it would be traumatic to have a dead body in your room. The CNA stated Resident C's body should have been removed from the room.<br><br>On [DATE], at 3:45 p.m., a review of Resident A ' s medical record was conducted. Resident A was admitted to the facility on [DATE]. 2024, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD- a group of lung problems that block airflow and make it difficult to breathe) and Fibromyalgia (a condition that involves widespread pain and tiredness). Resident A ' s history and physical, dated [DATE], indicated Resident A had the capacity to understand and make decisions.<br><br>On [DATE], at 4:25 p.m., an interview was conducted with Resident A. Resident A stated the staff did not ask her if she wanted to move to another room after Resident C died . Resident A stated she was very angry about the way things were handled. Resident A ' s family stated he was upset Resident A had to stay in the room with a dead body for so many hours, it was very inappropriate.<br><br>On [DATE], at 4:35 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the RN should have let her know Resident C had died , the body was in the facility too long. The DON stated the staff should have offered to move Residents A and B to another room. The DON stated the situation was not handled in an efficient way, the circumstances were not appropriate, and the expectations of the staff were not followed through well.<br><br>A review of the facility ' s policy titled, Quality of Life-Dignity, dated February 2020, indicated, .each resident will be cared for in a manner that promotes and enhances his or her sense of well-being .Residents are treated with dignity and respect at all times .Staff are expected to knock and request permission before entering residents ' rooms .standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents .<br><br>A review of the facility ' s undated policy titled, Resident Self Determination and Participation, indicated, . respects and promotes the right of each resident .what the resident considers to be important .facilitate resident choices .Residents are encouraged to make choices about aspects of their lives in the facility . |