

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 07/16/2025
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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with the facility's policy and procedures and physician's order, for four of four residents (Residents 1, 2, 3, and 4). This failure has the potential to result in reduced effectiveness of Residents 1, 2, 3, and 4's medications. On July 16, 2025, at 5:06 a.m., an unannounced visit was conducted at the facility to investigate quality of care issues. On July 16, 2025 at 5:23 a.m., during an interview with Licensed Vocational Nurse (LVN) 1, she stated she started the 6 a.m. and 6:30 a.m. medication pass (med pass - the process through which medication is administered to residents) at 4:20 a.m. LVN 1 stated she should start med pass at 5 a.m. but she started 40 minutes early because there were a lot of blood sugar checks, medications to be administered through G-tubes (gastrostomy tube - a tube inserted to the stomach used to give food and medications) and documentation to complete. LVN 1 stated she had just administered levothyroxine (medication to treat low thyroid hormone level) and omeprazole (medication to treat acid reflux) to Resident 1. LVN 1 stated she also administered insulin (medication to treat diabetes mellitus [abnormal blood sugar] to Resident 2 at 5:05 a.m. Resident 1's electronic Medication Administration Report (e-MAR), was concurrently reviewed with LVN 1. LVN 1 stated Resident 1's levothyroxine and omeprazole were scheduled at 6:30 a.m. LVN 1 further stated the facility's electronic health record system (PCC - Point Click Care) would not allow her to sign that she administered those medications earlier than 5:30 a.m. LVN 1 stated Resident 1 could have nausea or a little discomfort when her medications were given early. A review of Resident 2's e-MAR was conducted with LVN 1. LVN 1 stated Resident 2's long actin insulin was scheduled at 6:30 a.m. LVN 1 stated she administered Resident 2's insulin at 5:05 a.m. LVN 1 stated Resident 2's blood sugar could drop when her insulin was administered early. LVN 1 stated they were not providing quality of care because medication administration was started early. On July 16, 2025, at 5:43 a.m., during a concurrent observation and interview with Resident 3 in her room, Resident 3 was alert lying in bed and watching TV. Resident 3 stated she received her thyroid medication at 4:30 a.m. A review of Resident 3's admission Record indicated the resident was re-admitted to the facility on [DATE], with diagnoses which included hypothyroidism (low thyroid hormone level). A review of Resident 3's Order Summary Report, included a physician's order, dated January 9, 2025, which indicated, .Levothyroxine sodium Tablet 125 MCG (microgram - unit of measurement) Give 1 (one) tablet by mouth in the morning .Administer on an empty stomach, 30 minutes before breakfast . A review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated May 12, 2025, indicated Resident 3 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact). On July 16, 2025, at 6:02 a.m., Resident 4 was observed awake and alert lying in bed. In a concurrent interview, Resident 4 stated she was supposed to receive her insulin before each meal. Resident 4 stated there was a time when she received her insulin between 5 a.m. to 5:15 a.m. and breakfast was being served between 8:15 a.m. to 8:30 a.m. Resident 4 stated her blood sugar could drop if insulin is being administered earlier than ordered by the physician. A review of Resident 4's admission Record, indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus. A review of Resident 4's MDS, dated [DATE], indicated a BIMS score of 15. A review of Resident 4's Order Summary Report, included a physician's order, dated July 11, 2025, which indicated, .Novolog (short acting insulin) Injection solution 100 UNIT/ML .Inject 3 (three) unit .before meals . On July 16, 2025, at 6:30 a.m., during an interview with LVN 2, she stated she started 6:30 a.m. med pass at 4:30 a.m. because she would not be able to finish med pass on time before her shift ends. LVN 2 stated they used to have four (4) LVNs for med pass with 27 - 29 residents each but now they only have three (3) LVNs and had 36 - 38 patients each. LVN 2 stated when they had four LVNs, they were able to start and finish on time for medication pass. On July 16, 2025, at 6:47 a.m., during an interview with Registered Nurse Supervisor (RNS), he stated the LVNs would start their medication pass at around 4:30 a.m. so they could finish on time. On July 16, 2025, at 8:14 a.m., a follow up interview was conducted with LVN 1, she stated when medications were administered earlier than scheduled times, the physician should have been notified. On July 16, 2025, at 8:28 a.m., during a concurrent observation and interview, Resident 2 was in her room, lying in bed and awake. Resident 2 did not respond to interview questions. Resident 2's breakfast tray was observed on the overbed table. A review of Resident 2's admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which indicated diabetes mellitus. A review of Resident 2's Order Summary Report included a physician's order</p>		