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	04/20/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure necessary discharge planning was provided according to the facility's policy and procedure, for one of three residents reviewed (Resident 1), when Resident 1's family member (FM) was not informed of the resident's current functional limitations, required level of care, and if the FM was capable of providing care to Resident 1, prior to discharging back to home.This failure resulted in Resident 1 being discharged home and the FM could not provide the required assistance in ADLs (Activities of Daily Living). This failure had the potential for Resident 1's overall health condition to be affected and further decline in ADLs.Findings:On April 1, 2026, at 9:18 a.m., an unannounced visit to the facility was conducted to investigate issues regarding discharge.On April 1, 2026, a review of Resident 1's admission Record, indicated he was initially admitted to the facility on [DATE], with diagnoses which included fracture (break in the bone) of the right lower leg and osteomyelitis (a serious bone infection) on left ankle and foot. Resident 1 was discharged home on March 25, 2026.A review of Resident 1's Care Plan Report, initiated on December 14, 2025, indicated the resident or family's discharge plan was to discharge back to the community with his wife and for the facility to discuss discharge plan with resident/family as appropriate.A review of Resident 1's PT (Physical Therapy) Evaluation & (and) Plan of Treatment, dated December 15, 2025, indicated Resident 1's prior level of function was mostly independent with ADLs (activities daily living) including ambulation and he used a rollator walker for longer distances.A review of Resident 1's Physical Therapy Treatment Encounter Note(s), indicated the following:-On December 15, 2025, to March 12, 2026, indicated Resident 1 had non-weight bearing status to his left lower extremity and had weakness to his right lower extremity;-On March 17 and 23, 2026, Resident 1 performed five feet side steps using a front wheeled walker with moderate assistance (resident performs 50% of the task and the therapist provides 50% of the effort).A review of Resident 1's Case Management Notes, documented by Case Manager (CM), indicated the following:-December 30, 2025, at 11:49 a.m., .resident lives with wife in a single-story home, where patient plans on returning, resident walking independently at home with no assistive device.;-On March 6, 2026, at 2:46 p.m., .Place call to (name of Family Member [FM]).informed (name of FM) resident will exhaust benefits on 3-24-2026 (March 24, 2026) and will discharge home, (name of FM) replied resident lives at home with wife and daughter and family will assist with care at home.; and-On March 24, 2026, at 1:23 p.m., .During (name of insurance) meeting with (name of physician, CM, & SW (Social Worker), and our Rehab (rehabilitation) Dir (director), MD (physician) is aware resident will benefit exhaust (sic) on 3-24-26 and will discharge home as planned on 03-25-26 (March 25, 2026, resident will have 24 hour care at home with family to assist with care. Place call to (name of FM) to inform of discharge date , (name of FM) replied she is aware resident exhaust benefits today 36-24-26 and will discharge home on [DATE].There was no documented evidence that the FM was notified of Resident 1's current level of ADL functioning before he was to be discharged , that a caregiver training was offered, and if the family would be able to provide the required care for Resident 1. On April 1, 2026, at 11 a.m., during a telephone interview, Resident 1 stated he was discharged from the facility due to (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exhaustion of his insurance benefits. Resident 1 stated that FM 1 and additional family members are currently providing care for both himself and his wife. Resident 1 further indicated that he and his wife are bedridden, and he is presently unable to ambulate, though he previously walked independently.On April 1, 2026, at 12:33 p.m., during an interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 1. CNA 1 stated Resident 1 always liked to be in bed, he will only get up for physical therapy and shower. CNA 1 stated she never saw Resident 1 walk, but he can stand up on his own with a walker. CNA 1 stated she assisted FM 1 to get Resident 1 in the car when he was discharged .On April 1, 2026 at 1:29 p.m., during a concurrent record review of Resident 1's rehabilitation notes and interview with Occupational Therapist (OT) 1, OT 1 stated Resident 1 received physical and occupational therapy which started on December 15, 2025, and the resident was initially not ambulating due to a left foot wound infection with a wound vacuum (a medical device that uses gentle, controlled suction to help open or chronic wounds heal faster) and he had weakness from his hospital stay. OT 1 stated Resident 1 was also self-limiting as it was difficult to encourage the resident to participate with therapy even though he had capabilities. OT 1 stated Resident 1 was able to do five feet of side stepping along the edge of his bed on March 13, 2026. OT 1 stated Resident 1 was discharged home as planned and exhausted his benefits, and he required to have 24/7 (24 hours/7 days a week) care at home.On April 1, 2026, at 3:15 p.m., during a concurrent review of Resident 1's medical records and telephone interview with Case Manager (CM) 1, CM 1 stated discharge planning begins on admission, they talk to the resident or family members to find out what the plan is. CM 1 stated they do not discharge residents without a safe plan including having a place to go and family to support them. CM 1 Resident 1 was part of her case load. CM 1 stated the initial discharge plan for Resident 1 was to go home and she spoke with FM 1 on March 6, 2026, that the plan is for him to go home and that his benefits were exhausting on March 24, 2026. CM 1 stated Resident 1 was walking independently at home prior to hospitalization and was only doing side steps in the facility. CM 1 stated she talked to FM 1 about discharge plans to home but did not discuss regarding Resident 1's ambulation status of only able to do side steps while at facility. CM 1 stated caregiver training is offered prior to discharge. CM 1 stated she does not remember if caregiver training was offered to FM 1 as she thought FM 1 already knew what care was to be provided to Resident 1.On April 2, 2026, at 11:46 a.m., during a telephone interview, FM 1 stated Resident 1 used to be independent before hospitalization. FM 1 stated she only talked to CM 1 in the facility, and that CM 1 informed her that Resident 1 would need 24/7 care at home and when she asked what that meant, CM 1 just told her they would take it week by week because they meet weekly. FM 1 stated she did not know Resident 1 could not walk and CM 1 did not mention this to her. FM 1 stated she was not ready for the kind of care Resident 1 needed. FM 1 stated Resident 1's physician in the facility did not speak with her. FM 1 stated the facility did not offer caregiver training. FM 1 stated on the day of discharge, she picked up Resident 1 in the facility, a staff member assisted her to put Resident 1 in her car, and she noticed that he could not stand and when they reached home, she had to call another family member to help her get Resident 1 out of the car and they had to call the paramedics, twice on separate occasions, to help them put Resident 1 back to bed.On April 2, 2026, at 10:34 a.m., during an interview, Physical Therapist (PT) 1 stated they have (name of insurance company) meeting every Tuesday where they discuss when a resident is expected to be discharged , or if caregiver training is needed. PT 1 stated the CMs would let them know if the family would need caregiver training. PT 1 stated caregiver training depends on cognition of the resident. PT 1 stated if the resident could not demonstrate ADLs, they would involve the family members. PT 1 stated she did the evaluation for Resident 1, but she did not treat him every day. PT 1 stated she would recommend Resident 1 to have assistance at home because he was not independent with toileting, bed mobility, transfer, toileting and car transfer.On April 2, 2026, at 1:43 p.m., during an interview, the Administrator (AD) stated the Therapy, CM or Social Service Director explains to the family and give them a full picture of what the resident's functioning is, so the family knows what to expect and if they have the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right accommodations for the resident at home; and if they did that then they have to document. A review of the facility's policy and procedure titled Discharge Summary and Plan, dated March 2025, indicated, .Every resident will be evaluated for his or her discharge needs and will have an individualized post discharge plan .The post discharge plan will be developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and will include .the degree of caregiver/support person availability, capacity and capability to perform required care .