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	10/03/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47914 Based on record review and interview, the facility failed to notify the appropriate state-designated authority after a resident was diagnosed with a new mental illness for 1 (Resident #59) of 2 sampled residents reviewed for preadmission screening and resident review (PASARR) requirements. Findings included: An Admission Record revealed the facility admitted Resident #59 on 12/15/2023. According to the Admission Record, the resident had a medical history that included diagnoses of psychosis (onset 12/15/2023) and major depressive disorder (onset 12/15/2023). The Admission Record revealed the resident received a diagnosis of schizophrenia on 12/29/2023. An quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/2024, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had active diagnoses to include psychotic disorder and schizophrenia. Resident #59's care plan included a focus area initiated 12/25/2023, that indicated the resident had a mood problem related to admission to the facility, depression, psychosis, and a history of schizophrenia. Interventions directed staff to schedule behavioral health consultations as needed (initiated 12/25/2023), administer medications as ordered (initiated 12/25/2023), and report to the physician any signs or symptoms of depression, anxiety, or sad moods (initiated 12/25/2023). The care plan also indicated a focus area initiated 04/04/2024, that indicated the resident was at risk for increased confusion and disordered thought, secondary to schizophrenia. The care plan indicated the schizophrenia diagnosis was given by a psychiatrist on 12/29/2023. Interventions directed staff to provide psychiatry and psychology consultations as needed (initiated 04/04/2024). The care plan also revealed a focus area initiated 06/25/2024, that indicated the resident had psychosis behavior manifested by auditory hallucinations. Resident #59's medical record revealed no evidence that indicated a referral was made to the appropriate state-designated authority following the resident's new diagnosis of schizophrenia on 12/29/2023. (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/02/2024 at 1:25 PM, Social Services (SS) #7 stated she was not necessarily responsible for PASARR screenings. She stated the Level I screenings were usually done at the hospital prior to the resident's admission, and once it was received, a resident could be admitted . SS #7 stated if a resident had a change in condition, whether physical or mental, the facility would do a review and if needed, a new Level I screening would be completed. SS #7 stated Resident #59's psychosis diagnosis was temporary, and when the psychiatrist saw Resident #59, the psychiatrist determined that the resident had schizophrenia. SS #7 stated the resident's mental status did not change, and the resident did not have a change in condition, so that information would not necessarily need to be on the Level I screening. SS #7 stated that if there was a change in a resident's condition, Registered Nurse (RN) #8 was responsible for completing another Level I screening, and if RN #8 was not able to, then she would complete it. During an interview on 10/02/2024 at 2:06 PM, RN #8 stated she worked together with an MDS coordinator and a social worker on the PASARR process. She stated that when a PASARR screening was received, a resident would come into the facility, and it was uploaded into the resident's electronic health record. RN #8 stated that she believed she would not do a new Level I screening for a new diagnosis, but would for a new order of psychotropic medication. RN #8 stated that she would complete the new Level I screening and if she did not, another member of the team would complete it.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PASARR screening for Mental disorders or Intellectual Disabilities 31524 Based on record review, interview, and facility policy review, the facility failed to ensure the accuracy of Level I preadmission screening and resident review (PASARR) for 2 (Resident #3 and Resident #59) of 2 sampled residents reviewed for PASARR requirements. Findings included: A facility policy titled, Admission Criteria, revised in 09/2023, revealed, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. The policy revealed, a. The facility will ensure PASARR screen has been completed by hospitals or facility of origin for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. 1. An Admission Record revealed the facility admitted Resident #3 on 06/16/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia (onset 06/16/2024), schizophrenia (onset 06/16/2024), and major depressive disorder (onset 06/16/2024). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/23/2024, revealed Resident #3 had severe impairment in cognitive skills for daily decision making and short-term and long-term memory problems per a Staff Assessment for Mental Status (SAMS). Resident #3's care plan revealed a focus area initiated 08/16/2024, that indicated the resident required antipsychotic medication for schizophrenia. Interventions directed staff to administer medications as prescribed by the physician (initiated 08/16/2024) and to monitor for behaviors every shift (initiated 08/16/2024). The care plan revealed a focus area initiated 06/17/2024, that indicated the resident needed antidepressant medication. Interventions directed staff to administer medications as ordered (initiated 06/17/2024) and to monitor for side effects (initiated 06/17/2024). Resident #3's Preadmission Screening and Resident Review Level I Screening, dated 06/14/2024, revealed the resident did not have serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disorder. During an interview on 10/02/2024 at 1:25 PM, Social Services #7 stated Resident #3's Level I screening was inaccurate. During an interview on 10/02/2024 at 2:06 PM, Registered Nurse #8 stated Resident #3's Level I screening was inaccurate because it did not indicate the resident's mental illness diagnoses. During an interview on 10/02/2024 at 2:20 PM, the Director of Nursing stated Resident #3's Level I screening was not accurate. During an interview on 10/02/2024 at 2:35 PM, the Administrator stated Resident #3's Level I screening was inaccurate. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	47914 2. An Admission Record revealed the facility admitted Resident #59 on 12/15/2023. According to the Admission Record, the resident had a medical history that included diagnoses of psychosis (onset 12/15/2023), major depressive disorder (onset 12/15/2023). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/2023, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had active diagnoses to include depression and psychotic disorder. Resident #59's care plan included a focus area initiated 12/25/2023, that indicated the resident had a mood problem related to admission to the facility, depression, psychosis, and a history of schizophrenia. Interventions directed staff to schedule behavioral health consultations as needed (initiated 12/25/2023), administer medications as ordered (initiated 12/25/2023), and report to the physician any signs or symptoms of depression, anxiety, or sad moods (initiated 12/25/2023). Resident #59's Preadmission Screening and Resident Review Level I Screening, dated 12/15/2023, revealed the resident did not have serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disorder. During an interview on 10/02/2024 at 1:25 PM, Social Services (SS) #7 stated a resident's Level I screening was usually completed at the hospital prior to admission, and once it was received, a resident could be admitted . SS #7 stated that a review of the screening was not completed for accuracy upon admission because the facility relied on the hospital to do their due diligence to make sure the documents were accurate. SS #7 stated that Resident #59's Level I screening was completed on the same day the resident discharged from the hospital, and the facility staff would have anticipated the information on the screening to be accurate. S #7 stated that the hospital staff should have placed the resident's psychosis diagnosis on the Level I screening that was completed on 12/15/2023. During an interview on 10/02/2024 at 2:06 PM, Registered Nurse (RN) #8 stated that the diagnosis of psychosis should have been on Resident #59's Level I screening completed on 12/15/2023. During an interview on 10/02/2024 at 2:20 PM, the Director of Nursing (DON) stated that Level I screenings were completed at the hospital and sent to the facility before a resident was accepted, and it was then uploaded into the resident's electronic health record. The DON stated that the importance of the Level I screening being completed was for residents that had a mental illness to get a second screening to ensure the resident got all the proper services they needed. The DON stated that PASARRs were not reviewed for accuracy, but if the Level I screening triggered a Level II evaluation, the facility would request that before the resident came. The DON stated that she did a review of Resident #59's Level I screening and it was inaccurate. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/02/2024 at 2:34 PM, the Administrator stated that the hospital completed the Level I screenings and the facility staff were not to accept any residents without one. The Administrator stated that the PASARR screening evaluated the mental capacity of a resident. The Administrator stated that during review of the Level I screenings, staff looked to make sure the resident did not require a Level II evaluation. The Administrator stated that he felt that when a Level I screening was inaccurate, it would mislead the facility about the resident.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 28193 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the medication error rate was 5% or less. This was evidenced by two medication errors out of 33 opportunities, which resulted in a medication error rate of 6.06%, that affected 2 (Resident #10 and Resident #39) of 5 residents observed for medication administration. Findings included: A facility policy titled, Administering Oral Medications, revised in 09/2023, revealed, The purpose of this procedure is to provide guidelines for the safe administration of oral medications. The policy further revealed, Steps in the Procedure included 5. Select the drug from the unit dose drawer or stock supply. 6. Check the label on the medication and confirm the medication name and dose with the MAR [medication administration record]. 1. An Admission Record revealed the facility admitted Resident #10 on 01/10/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified anemia. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/16/2024, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #10's care plan included an undated focus area that indicated the resident had an altered nutrition need related to diagnoses that included anemia. Interventions directed staff to administer ferrous fumarate (initiated 01/16/2024). Resident #10's Order Summary Report, which listed active orders as of 10/01/2024, revealed an order dated 01/31/2024, for ferrous fumarate oral tablet 324 milligrams (mg), one tablet by mouth three times a day for a supplement. During an observation of medication administration on 10/01/2024 at 8:16 AM, Licensed Vocation Nurse (LVN) #6 prepared and administered a ferrous sulfate 325 mg tablet to Resident #10. 2. An Admission Record revealed the facility admitted Resident #39 on 09/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of adult failure to thrive, unspecified dementia, and follicular lymphoma. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/16/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Resident #39's care plan included a focus area initiated 09/04/2024, that indicated the resident was at risk for constipation due to a diagnosis of chronic constipation. Interventions directed staff to administer medication as ordered (initiated 09/04/2024). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39's Order Summary Report, which listed active orders as of 10/01/2024, revealed an order dated 09/03/2024, for Senna-S (sennosides-docusate sodium, a combination of a laxative medication and a stool softener medication) oral tablet 8.6 milligram (mg) - 50 mg, give two tablets by mouth two times a day for constipation; hold for loose stools. During an observation of medication administration on 10/01/2024 at 8:55 AM, Licensed Vocational Nurse (LVN) #6 prepared and administered medications to Resident #39, including one Geri-kot (sennosides) 8.6 mg tablet and one docusate sodium 100 mg capsule. During an interview on 10/02/2024 at 2:28 PM, the Director of Nursing (DON) stated she expected nurses to administer medications per the physician's orders, and to give the right medications. The DON stated that if a medication was unavailable as ordered, she expected the nurse to either call the physician to get another order, or come to her so the facility could make the correct medications available. During an interview on 10/02/2024 at 2:40 PM, the Administrator stated that he expected the nurses to pay attention and know the medications. The Administrator stated that he expected staff to stay below a 5% medication error rate, ideally at 0%.