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	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodcrest Post Acute & Rehabilitation	8133 Magnolia Avenue Riverside, CA 92504

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. F814 Dispose Garbage and Refuse ProperlyBased on observation, interview, and record review the facility failed to ensure two of two dumpster bin lids were fully closed.This failure had the potential to cause insects and rodents infestation in the facility and potential for food borne illness.Findings:On January 5, 2026, at 10:03 a.m., during concurrent observation and interview with the Dietary Service Supervisor (DSS), the dumpster was overloaded with garbage bags and the cover was open about a foot and a half. The DSS stated the dumpster was not fully covered. The DSS further stated the dumpsters should be covered to prevent insects and rodents' infestation.On January 8, 2026, at 11:23 a.m., during concurrent observation of picture of the dumpster and interview with the Registered Dietician (RD), the RD stated there were a lot of bags, and the lids were open. The RD further stated that the dumpster lids should be covered, and the main objective is to keep the rodents out.A review of the facility policy titled, .Garbage and Trash, dated 2023, indicated .Garbage and trashcan must be inspected daily.lids are closed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and treatment was provided, for two of 28 sample residents (Residents 83 and 100), when:1. Resident 83's refusal of medications was not addressed including identifying the reason for refusal, providing education and interventions, and evaluating the resident's response. There was no consistent documented evidence the physician was notified timely of Resident 83's refusal of medications.This failure had the potential to result in a delay in timely provision of care for Resident 83 and could contribute to complications related to medication not administered.2. Resident 100's abnormal laboratory (Hemoglobin A1C [HgbA1C - measures average blood sugar levels over the past 2-3 months]) result on October 16, 2025, was not addressed according to the facility's policy and procedure.This failure had the potential for Resident 100 to have uncorrected hyperglycemia (elevated blood sugar levels), and experience the side effects of hyperglycemia, such as neuropathy (disease nerves), retinopathy (disease retina [light sensitive tissue of the eye]), nephropathy (disease of the kidney) and coronary artery disease (heart disease). Findings: 1. On January 6, 2026, at 10:55 a.m., Resident 83 was observed lying in bed with head of bed slightly elevated. In a concurrent interview, Resident 83 stated she did not take any medications, since she did not need them and was not sick. A review of Resident 83's record indicated Resident 83 was admitted to the facility on [DATE], with diagnoses which included hemiparesis and hemiplegia following cerebral infarction (muscle weakness or partial paralysis on one side of the body following a stroke), atrial fibrillation (irregular and very rapid heart rhythm which increases the risk for stroke), and hypertension (high blood pressure, which increases the risk for stroke). A review of Resident 83's History and Physical Examination, dated May 15, 2025, indicated Resident 83 had the capacity to understand and make decisions. A review of Resident 83's Minimum Data Set (MDS), dated [DATE], indicated Resident 83 had a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). A review of Resident 83's Order Summary Report, included the following physician's orders: - Amiodarone HCl (hydrochloride) oral tablet 400 MG (milligram- unit of measurement), give one tablet by mouth every 12 hours for Cardiac Arrhythmias (irregular heart rhythms), date ordered May 2, 2024; - amlodipine Besylate oral tablet 10 MG.Give one tablet by mouth one time a day for HTN (hypertension – high blood pressure), hold (do not give) for SBP (systolic blood pressure- upper number of blood pressure reading) less than 100 or heart rate (HR) less than 60 beats per minute, date ordered May 2, 2024; - Apixaban oral tablet 5 (five) MG, give one tablet by mouth every 12 hours for atrial fibrillation (an irregular and often very rapid heart rhythm), date ordered May 2, 2024; - Clonidine Transdermal (applied on the skin) Patch weekly 0.2 MG/24HR (hour), apply one patch transdermally (on the skin) one time a day every Friday for hypertension, hold for SBP less than 100 or HR less than 60, place overlay patch cover and rotate site, and remove per schedule, date ordered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	May 2, 2024; and - Hydralazine HCl oral tablet, give 75 MG by mouth every six hours for hypertension, hold for SBP less than 100, date ordered May 2, 2024. A review of Resident 83's Care Plan Report, dated June 2, 2025, indicated, .Focus. Refusing medication .Interventions .Administer medication as ordered by physician. Monitor for effectiveness and any side effects .Evaluate effectiveness of medication . A review of Resident 83's Medication Administration Record (MAR), for the months of October, November, December 2025,and January 2026, indicated Resident 83 refused all doses of Amiodarone, Amlodipine, Clonidine patch, Hydralazine, and Apixaban. A review of Resident 83's MAR for the months of October, November, December 2025, and January 2026, indicated Resident 83's blood pressure were taken on the following dates with readings above the normal blood pressure range (120 mmHg/80 mmHg [millimeters of mercury]): -October 1, 2025: 139/65 mmHg -October 6, 2025: 136/75 mmHg -October 12, 2025: 128/70 mmHg - October 13, 2025:133/65 mmHg -October 18, 2025: 158/76 mmHg (systolic high of 139 exceeded) -October 26, 2025: 132/71 mmHg - October 31, 2025: 139/72 mmHg -November 5, 2025: 132/65 mmHg -November 6, 2025: 142/73 mmHg (systolic high of 139 exceeded) - November 07, 2025: 142/66 mmHg (systolic high of 139 exceeded) - November 9, 2025: 124/80 mmHg - November 11, 2025: 135/74 mmHg - November 12, 2025: 131/65 mmHg - November 14, 2025: 122/62 mmHg - November 18, 2025: 135/60 mmHg - November 24, 2025: 141/74 mmHg (systolic high of 139 exceeded) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- November 27, 2025: 134/81 mmHg -December 1, 2025: 143/59 mmHg, Amiodarone given, all other meds refused - December 17, 2025: 143/71 mmHg (systolic high of 139 exceeded) - December 18, 2025: 130/68 mmHg - December 23,2025: 141/60 mmHg - December 24,2025: 136/71 mmHg - December 25, 2025: 126/68 mmHg - December 28,2025:133/69 mmHg There were no blood pressure readings documented on other days in December 2025. There was no documented evidence blood pressure was monitored for January 2026. A review of Resident 83's licensed nurses' and physician's progress notes did not indicate consistent periodic evaluation addressing Resident 83's medication refusals, reasons for refusal, or interventions implemented to address elevated blood pressure readings when Resident 83 refused her blood pressure medications. A review of Resident 83's quarterly IDT (interdisciplinary team – a group of healthcare professionals) Care Conference notes, dated August 15, 2025, and November 11, 2025, did not indicate Resident 83's pattern of medication refusals was addressed. On January 8, 2025, at 2:19 p.m., an interview and record review for Resident 83 was conducted with the Assistant Director of Nursing (ADON). The ADON acknowledged that Resident 83 had been refusing medications and vital signs for at least a year. The ADON stated they would notify the physician, encourage compliance, and explain the risks and benefits to the resident. On January 8, 2025, at 2: 55 p.m., Licensed Vocational Nurse (LVN) 3 was interviewed. LVN 3 stated she was aware Resident 83 always refused her medications. LVN 3 stated that the facility's process for medication refusal involved contacting the physician for a care plan but could not specify the plan for Resident 83. On January 8, 2025, at 4:19 p.m., a concurrent interview and review of Resident 83's record was conducted with the Director of Nursing (DON). The DON stated she was aware Resident 83 has been refusing medications. The DON confirmed Resident 83's consistent refusal of medications from October 2025 to January 2026. The DON further stated the licensed nurses' progress notes, weekly summary and the IDT quarterly care conference notes should have included documentation regarding Resident 83's refusal of medications, physician notification of refusals, and the plans of care pertaining to the refusals. A review of the facility's policy and procedure titled, Refusal of Medication & Treatment and Notification of Physician Policy, revised September 2025, indicated, .To ensure resident rights ae respected while maintaining patient safety through timely assessment, documentation, and prompt (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notification of the attending physician when a resident refuses medications and treatments.When a refusal occurs, the facility shall assess the resident, provide education, document the refusal, notify the physician when required, and implement follow-up interventions as clinically indicated.Immediate Nursing Actions.Assess the resident and determine the reason for refusal.Educate the resident on risks and benefits.Attempt reasonable interventions.Documentation.Reason for refusal.Education provided.Interventions attempted.Resident response.Documentation must be entered in the eMAR/TAR (treatment administration record) and nursing notes.Physician Notification.The physician must be notified when.Medication is refused 3 consecutive times.After a pattern of refusal is identified. 2. A review of Resident 100's admission Record, indicated Resident 100 was admitted to the facility January 15, 2025, with diagnoses which included diabetes mellitus (high blood sugar). A review of Resident 100's blood sugar monitoring for August, September, and October 2025, indicated the resident's blood sugar level was within the range of 351- 400 mg/dl (milligram/deciliter - unit of measurement; the normal blood sugar range is 70-130 mg/dl) with the following number of episodes per month: - August 2025; 16 times; - September 2025, 26 times; and - October 2025, 31 times. A review of Resident 100's physician's order, dated October 15, 2025, indicated, .HGB A1C lab (laboratory) draw October 16, 2025. A review of Resident 100's lab report indicated, .Blood Chemistry: Procedure: HGBA1C Result: 9.1 % Reference Range (4.6- 7.4) . Further review of Resident 100's record indicated there was no documented evidence Resident 100's HgbA1C of 9.1% was addressed. On January 6, 2026, at 3:34 p.m., during a concurrent interview and record review with Licensed Vocational Nurse (LVN) 1, LVN 1 indicated that the elevated Hemoglobin A1c result from October 16, 2025, should have been promptly referred to the physician. LVN 1 further remarked that it should have been identified earlier. On January 6, 2026, at 3:50 p.m., during a concurrent interview and record review with Registered Nurse (RN) 1, RN 1 stated the HgbA1c result was referred to the physician on October 31, 2025 (15 days from the date of laboratory results on October 16, 2025). RN 1 stated the elevated HgbA1C should have been referred to the physician promptly. RN 1 further stated the potential side effects of hyperglycemia included neuropathy (nerve damage, usually starting in the hands and feet) and retinopathy (complication of diabetes that affects the eye). On January 9, 2026, 3:56 p.m., during a concurrent interview with the Director of Nursing (DON), the DON stated all abnormal results should be reported to the physician timely. The DON further stated the physician should have been notified of the result, and the notification should have been documented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Diabetes – Clinical Protocol, dated November 2024, indicated, .the Physician will order appropriate lab tests (for example, periodic finger sticks or A1C) and adjust treatments based on these results. A review of the facility's policy and procedure titled, Physician Orders and Physician Notification, dated November 2025, indicated, .The physician shall be notified of.abnormal findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services were provided to meet the needs of the residents when:1. For Resident 76, a discontinued controlled substance (CS) was not removed from active medication storage, tablets continued to be removed from inventory after the physician order was discontinued. In addition, the documentation on the controlled drug record (CDR - medication count sheet, an inventory record used to document the receipt, use, and count of controlled substances) did not reconcile with the Medication Administration Record (MAR) and the CS was administered after the CS was discontinued; and2. For Resident 120, documentation on the CDR did not reconcile with the MAR.These failures resulted in inaccurate accountability of controlled substances, which had the potential for diversion (medication taken by someone other than for whom it is prescribed) or misuse of controlled substances and had the potential to compromise residents' medication therapy and safety. Findings:1. On January 6, 2026, at 2:25 p.m., during an inspection of Medication Cart 1 at Nursing Station 1 with Licensed Vocational Nurse (LVN) 4, a blister card of hydrocodone-acetaminophen (generic for Norco, a controlled substance [CS] pain medication) 5-325 mg (milligram - unit of measurement), labeled for Resident 76 was observed stored in the medication cart with active medications. During a concurrent interview and record review with LVN 4, LVN 4 stated Resident 76 was admitted to the facility on [DATE], with diagnosis which included peripheral vascular disease (a slow, progressive circulation disorder involving narrowed, blocked, or spasmodic blood vessels outside the heart and brain, most commonly affecting the legs and feet). A review of the physician's order indicated Resident 76 had an order for hydrocodone-acetaminophen 5-325 mg, give 1 (one) tablet by mouth every 8 (eight) hours as needed for moderate to severe pain, dated December 22, 2025, which was discontinued on December 31, 2025, at 1:14 p.m. LVN 4 confirmed the medication had been discontinued on December 31, 2025, and the discontinued CS had not been removed from the medication cart. LVN 4 stated discontinued CS medications should have been removed from the medication cart and given to the Director of Nursing (DON) for destruction.On January 6, 2026, at 2:25 p.m., during a concurrent interview and record review with LVN 4, Resident 76's CDR indicated the nursing staff removed and signed out one tablet of hydrocodone-acetaminophen 5-325 mg on December 25, 2025, at 9 a.m. prior to discontinuation. However, there was no corresponding documentation of administration and pain assessment on December 2025 MAR for the tablet removed on December 25, 2025, at 9 a.m.Resident 76's CDR indicated the hydrocodone-acetaminophen was administered to Resident 76 after the CS was discontinued on December 31, 2025, on the following dates:- January 1, 2026, at 0521 (5:21 a.m.);-January 4, 2026, at 0340 (3:40 a.m.); and-January 5, 2026, at 0227 (2:27 a.m.).A review of January 2026 MAR showed no active physician's order for hydrocodone-acetaminophen 5-325 mg following the discontinuation of the medication on December 31, 2025. In a concurrent interview with LVN 4, she confirmed the discrepancy between the CDR and the MAR and stated the CS administrations are required to be documented on both the CDR and MAR and the medication including CS should not be administered without a current physician order.Review of Resident 76's progress notes dated December 31, 2025, at 1:14 p.m., indicated the physician order to discontinue Norco. On January 8, 2025, at 1:59 p.m., during a concurrent interview and record review with LVN 5, LVN 5 stated the nursing staff are notified of medication discontinuations verbally and through the PCC (PointClickCare, a cloud-based electronic health record (EHR) and care coordination platform designed for the long-term and post-acute care settings) communication tool and the discontinued medications no longer appear on the MAR. LVN 5 stated the nursing staff were required to verify active physician orders prior to administration and void tablet removal on the CDR if a medication is discontinued. LVN 5 stated if a discontinued medication is administered, nursing staff are required to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notify the physician, follow the physician's instructions, and document the event in a progress note. LVN 5 confirmed there were no progress notes for Resident 76 on January 1, 4, or January 5, 2026, corresponding to the Norco tablet removals documented on the CDR.On January 8, 2026, at 2:15 p.m., during a concurrent interview and record review with Registered Nurse (RN) 2, RN 2 stated the nursing staff are notified verbally of discontinued medication orders so the assigned LVN could remove the medications from the medication cart. RN 2 confirmed he notified the LVN assigned to Resident 76 of the physician's discontinuation order for Norco and documented the discontinuation in a progress note on December 31, 2025, at 1:14 p.m.On January 8, 2026, at 2:30 p.m., during a concurrent interview with Resident 76 in the resident's room with assistance from LVN 5 for Spanish translation, Resident 76 stated he received pain medications whenever he reported pain to nursing staff. However, Resident 76 stated he could not recall which pain medication he received on December 25, 2025, January 1, January 4, and January 5, 2026. Resident 76 stated the nursing staff assessed his pain level before and after administering pain medication. Resident 76 stated he did not like Norco due to hallucinations and visual disturbances he had experienced, and stated Tylenol (acetaminophen - pain medication) helped his pain. On January 8, 2026, at 4:10 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON reviewed Resident 76's CDR and MARs and stated the following:-Confirmed one tablet of hydrocodone acetaminophen 5-325 mg were documented as removed from the blister card on the CDR on December 25, 2025, without corresponding documentation of administration on the MAR, and additional tablets were documented as removed on January 1, January 4, and January 5, 2026, after the physician's order had been discontinued on December 31, 2025;-Her expectation for the nursing staff was to remove the discontinued medications from active medication storage upon receipt of a discontinuation order and follow proper procedures for CS destruction;-The nursing staff were required to document medication administration on the MAR, document CS removal on the CDR, and report any discrepancies identified during CS reconciliation;-The nurse who documented the tablet removals was unavailable for interview during the survey period, and the facility was unable to verify whether the tablets documented as removed were administered to Resident 76 or otherwise accounted for;-After the discrepancy was identified on January 6, 2026, the facility interviewed Resident 76, who reported experiencing adverse effects with Norco and stated he did not like Norco or Tramadol (pain medication). The DON stated this was the first time the facility became aware of Resident 76's reported adverse effects;A review of the facility's policy and procedures (P&P) titled, Discontinued Medications, dated January 16, 2025, indicated, .Medications are removed from the medication cart immediately upon receipt of an order to discontinue to avoid inadvertent administration.Discontinued medications not returned to the pharmacy are destroyed in accordance with the facility destruction policy and procedure.A review of the facility's P&P titled, Controlled Substances, dated November 2025, indicated, .Controlled substances remaining in the facility after the order has been discontinued.securely locked in an area with restricted access until destroyed.A review of the facility's P&P titled, Physician Orders and Physician Notification, dated November 2025, indicated, .The facility ensures that all resident care is provided in accordance with timely, complete, and authenticated physician orders.Orders shall be implemented promptly.Resident response shall be monitored.Physicians shall be notified of.incidents.unresolved pain.resident/family concerns.Licensed Nurses: Identify changes, notify physicians, document accurately, and implement orders.2. On January 6, 2026, at 2:25 p.m., during an inspection of Medication Cart 1 at Nursing Station 1 a blister card for oxycodone (CS pain medication) 5 mg labeled for Resident 120 was concurrently reviewed with LVN 4.A review of Resident 120's admission Record, indicated Resident 120 was admitted on [DATE], with diagnoses which included osteoarthritis (a degenerative joint disease characterized by the breakdown of cartilage-the protective, slippery tissue that cushions joints. It causes chronic joint pain, stiffness, reduced range of motion, and swelling, primarily affecting hands, knees, hips, and the spine).A review of Resident 120's physician order indicated an order for oxycodone 5 mg, give 1 (one) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tablet by mouth every 6 (six) hours as needed for severe pain management 7-10 (pain scale), dated December 28, 2025.A review of Resident 120's CDR and December 2025 and January 2026 MARs indicated the nursing staff removed and signed out one tablet of oxycodone 5 mg on December 31, 2025, at 2342 (11:42 p.m.) and January 4, 2026, at 0015 (12:15 a.m.), but there was no corresponding documentation of administrations and pain assessments on the MAR. LVN 4 confirmed the discrepancy and stated the CS administrations were required to be documented on both the CDR and the MAR.On January 7, 2026, at 12:50 p.m., during a concurrent interview and record review with the DON, the DON confirmed discrepancies between the CDR and the MAR for Resident 120, including documented CS removals without corresponding MAR documentation of administration. The DON stated her expectation for nursing staff was to document CS removal on the CDR and document medication administration on the MAR.A review of the facility's P&P titled, Administering Medications, dated February 2025, indicated, .Medications administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders.The individual administering the medication checks the label to verify.right medication.right time.before giving the medication.As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered.e. any complaints or symptoms for which the drug was administered; f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug.A review of the facility's P&P titled, Controlled Substances, dated November 2025, indicated, 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders and the facility's policies and procedures, when a medication error rate of 20% was identified, with five medication errors out of 25 medication administration opportunities during medication pass observations for three of five residents observed (Residents 22, 61, and 110).These failures included administration of incorrect medication, incorrect dosage form, and incorrect dose, which had the potential to compromise residents' medication therapy and safety. Findings:1. On January 5, 2026, at 9:33 a.m., during a medication administration observation with Licensed Vocational Nurse (LVN) 2, LVN 2 was observed preparing and administering seven medications to Resident 22, including a red round multivitamin (MVI - supplement) tablet and an aspirin (used to prevent blood clots) 81 mg (milligram - unit of measurement) chewable tablet.A review of Resident 22's physician orders indicated the following: - Multivitamin-Minerals Oral Tablet (Multiple Vitamins w/ Minerals - supplement), Give 1 (one) tablet by mouth one time a day for Supplement, dated November 18, 2025; and- Aspirin Low Dose Oral Tablet Delayed Release (designed to release the drug later after ingestion rather than immediately) 81 mg (aspirin), give 1 (one) tablet by mouth one time a day for CVA (cardiovascular accident - stroke) PPX (prophylaxis - preventive medication given to prevent a disease), Give with Food, dated November 18, 2025.On January 5, 2026, at 12:52 p.m., during a concurrent interview and record review with LVN 2, LVN 2 confirmed one-daily multivitamin tablet and aspirin 81mg chewable tablet were administered to Resident 22 instead of the ordered multivitamin-mineral tablet and delayed-release aspirin. LVN 2 stated she should have verified the right medication and right dosage form prior to administration.On January 6, 2026, at 11:14 a.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON reviewed Resident 22's orders and stated the correct medication and correct dosage form of medication should have been administered as ordered by the physician. 2. On January 5, 2026, at 10:04 a.m., during a medication administration observation, LVN 3 was observed preparing and administering seven medications to Resident 61, including Vitamin D3-5 Cholecalciferol (supplement) 5,000-unit (unit of measurement) capsule and Vitamin B12 (supplement) 500 mcg (microgram - unit of measurement) tablet.A review of Resident 61's physician orders indicated the following:- Cholecalciferol (vitamin D3 - supplement) Tablet 1,000 UNIT, give 1 (one) tablet by mouth one time a day for SUPPLEMENT, dated November 6, 2025; and- Vitamin B12 Oral Tablet 1000 mcg (Cyanocobalamin -supplement), give 1 (one) tablet by mouth one time a day for SUPPLEMENT, dated November 7, 2025.On January 5, 2026, at 12:34 p.m., during a concurrent interview and record review with LVN 3, LVN 3 confirmed a 5,000-unit Vitamin D3 capsule was administered instead of the ordered 1,000 unit and Vitamin B12 500 mcg was administered instead of the ordered 1,000 mcg. LVN 3 stated she should have verified the right dose prior to administration.On January 6, 2026, at 11:14 a.m., during a concurrent interview and record review with the DON, the DON reviewed Resident 61's orders and stated the correct dose should have been administered as ordered by the physician.3. On January 5, 2026, at 10:22 a.m., during a medication administration observation LVN 3 was observed preparing and administering seven medications to Resident 110, including 20 mL (milliliter - unit of measurement) of lactulose (used to treat constipation) oral solution.A review of Resident 110's physician order indicated Lactulose Oral Solution 20 GM (gram - unit of measurement)/30 ML (Lactulose), Give 30 mL by mouth two times a day for constipation. Hold for loose stool, dated December 28, 2025. On January 5, 2026, at 12:45 p.m., during a concurrent interview and record review with LVN 3, LVN 3 confirmed 20 mL of lactulose was administered instead of ordered dose of 30 ml. LVN 3 stated she should have checked the right dose before administration.On January 6, 2026, at 11:14 a.m., during a concurrent interview and record review with the DON the DON reviewed Resident 110's lactulose order and stated correct dose should have been administered as ordered by the physician.A review of the facility's policy and procedures (P&P) titled, Administering Medications, (continued on next page)

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	055474	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodcrest Post Acute & Rehabilitation	8133 Magnolia Avenue Riverside, CA 92504

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated February 2025, indicated, .Medications are administered in accordance with prescriber orders.The individual administering the medication checks the label to verify .right medication, right dosage.before giving the medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented, for five out of nine residents reviewed for infection control practices when:1.For Resident 61, 110, and 111, nursing staff did not clean and disinfect shared medical equipment, wrist blood pressure (BP) monitor with an attached cuff, before and after each use, in accordance with the facility's infection control policy; 2.One housekeeper (HK) did not perform hand hygiene after removing PPE (personal protective equipment- like gowns, gloves, masks, worn to minimize exposure to hazards) used while cleaning an EBP (enhanced barrier precautions- infection control measures, primarily for nursing homes, that mandate gowns and gloves for healthcare workers during high-contact resident care to prevent the spread of multidrug-resistant organisms) room (room [ROOM NUMBER]); and3.The facility failed to follow the facility's standards of practice when a nasal cannula (a medical device used to deliver supplemental oxygen) was not changed weekly for one of three residents reviewed (Resident 14).These failures had the potential to expose residents to infection and compromise residents' health and safety in the facility.Findings: 1a. On January 5, 2026, at 9:52 a.m., during a medication administration observation Licensed Vocational Nurse (LVN) 3 was observed using a wrist BP monitor with an attached cuff to obtain Resident 111's blood pressure in the resident's room. After obtaining blood pressure reading, LVN 3 was observed placing the used wrist BP monitor with attached cuff on top of the medication cart without cleaning or disinfecting the equipment. 1b. On January 5, 2026, at 10:04 a.m., during a medication administration observation LVN 3 was observed using the same wrist BP monitor with attached cuff that had not been cleaned or disinfected after the prior use to obtain Resident 61's blood pressure in the resident's room. After obtaining blood pressure reading, LVN 3 was observed placing the used wrist BP monitor with attached cuff on top of the medication cart without cleaning or disinfecting the equipment. 1c. On January 5, 2026, at 10:25 a.m., during a medication administration observation LVN 3 was observed using the same wrist BP monitor with attached cuff that had not been cleaned or disinfected after the prior use to obtain Resident 110's blood pressure in the resident's room. After obtaining blood pressure reading, LVN 3 was observed placing the used wrist BP monitor with attached cuff on top of the medication cart without cleaning or disinfecting the equipment. On January 5, 2026, at 12:30 p.m., during an interview with LVN 3, LVN 3 acknowledged the wrist BP monitor with attached cuff was returned to the medication cart without being cleaned or disinfected after each use for Resident 111, 61, and 110. LVN 3 stated the wrist BP monitor with attached cuff is shared equipment and should have been cleaned and disinfected before and after each use with wipes in the purple cap container (Sani-Cloth germicidal [disinfectant that kills germs such as bacteria and viruses] disposable wipes) available in the medication cart for infection control. On January 5, 2026, at 4:03 p.m., during an interview with the Infection Preventionist (IP), the IP stated the wrist BP monitor with attached cuff is considered a shared medical equipment and is required to be cleaned and disinfected before and after each use for infection control prevention. The IP stated nursing staff may use either wipes in the purple cap container (Sani-Cloth germicidal disposable wipes) or bleach wipes in the blue cap containers (CaviWipes Bleach disposable wipes) to clean and disinfect the equipment. The IP confirmed these products are facility-approved disinfectants available in each medication cart and are required to be used in accordance with the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's infection control policy. On January 6, 2026, at 11:14 a.m., during an interview with the Director of Nursing (DON), the DON stated any shared medical equipment, including the wrist BP monitor with attached cuff must be cleaned and disinfected with disinfectant wipes before and after each use to prevent the spread of infection, such as bacteria and viruses. A review of the facility's policies and procedures titled, Cleaning and Disinfecting of Resident-Care Items and Equipment, dated September 2025, indicated, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention - a nationally recognized disease control and prevention organization) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration – a government agency for workplace safety) Bloodborne Pathogens (disease-causing germs, like viruses or bacteria in human blood and other body fluids that can cause disease in people) Standard.Non-critical items are those that come in contact with intact skin. Non-critical resident-care items include.blood pressure cuffs.Reusable items are cleaned and disinfected.(e.g., stethoscopes, durable medical equipment).Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident.Intermediate and low-level disinfectants for non-critical items include: a. ethyl or isopropyl alcohol; b. sodium hypochlorite (5.25-6.15% diluted 1:50 or per manufacturer's instructions); c. phenolic germicidal detergents; d. iodophor germicidal detergents; and e. quaternary ammonium germicidal detergents (low-level disinfection only). 2. On January 6, 2026, at 11:56 a.m., Housekeeper (HK) 1 was observed to enter an Enhanced Based Precaution room; after doffing her PPE (Personal Protective Equipment) she was not observed to follow hand hygiene. On January 6, 2026, at 12 p.m., during an interview with HK 1, she stated she should have done hand hygiene right after the PPE was doffed. HK 1 further stated it had the potential to cause cross-contamination. On January 8, 2026, at 10:06 a.m., the IP was interviewed. The IP stated hand hygiene is indicated in many instances, including hand hygiene should be performed prior to donning PPE and after doffing PPE. The IP stated hand hygiene is important to decrease instances of infection for all residents and staff. A review of facility's policy and procedure titled, Handwashing/hand Hygiene, dated November 2025, indicated .Use an alcohol- based hand rub Hand sanitizer after removing gloves; before and after entering isolation precaution room. 3. On January 6, 2026, at 9:26 a.m., a concurrent observation and interview was conducted with Resident 14 inside the resident's room. Resident 14 was observed using oxygen via nasal cannula at 2 L/min (liters per minute – a unit of measurement). Resident 14's nasal cannula tubing was observed with the date 12/29/25 (December 29, 2025) written in black permanent marker near the tubing connector point. Resident 14 stated she used oxygen continuously. A review of Resident 14's admission Record, dated January 8, 2026, indicated an admission date of November 8, 2024, with diagnoses which included shortness of breath. A review of Resident 14's History and Physical, dated November 13, 2025, indicated Resident 14 had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluctuating capacity to understand and make decisions. A review of Resident 14's Physician Orders, dated November 8, 2024, indicated, .CHANGE NASAL CANNULA QSUN (every Sunday) every night shift every Sun (Sunday). On January 6, 2026, at 9:56 a.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 2 in Resident 14's room. LVN 2 stated the nasal cannula tubing was observed with the date 12/29/25 (December 29, 2025) written in black permanent marker near the tubing connector point. LVN 2 stated the nasal cannula was dated a week past and should have been changed according to the facility's standards of practice. LVN 2 stated oxygen tubing should be changed weekly on Sundays. LVN 2 stated it was important to change the nasal cannula weekly to prevent cross contamination related to infection control issues. On January 8, 2026, at 9:49 a.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the oxygen tubing should be changed weekly on Sundays and as needed. The ADON stated the licensed nurse should have changed Resident 14's nasal cannula in accordance with facility practice. The ADON stated it was important to change the nasal cannula weekly to prevent infections to the residents. A review of the facility's policy and procedure titled, OXYGEN DELIVERY, NASAL CANNULA, dated July 21, 2025, indicated, .Change the nasal cannula once a week and PRN (as needed) and discard after use.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide fingernail care, for one of one resident reviewed for Activities of Daily Living (ADL) (Resident 94), when her fingernails were observed to be long, yellowish, and with black residue underneath the fingernails.This failure had the potential to result in an increased risk of infection and injury due to unclean fingernails.Findings:On January 5, 2026, at 2:50 p.m., a concurrent observation and interview was conducted with Resident 94 in her room. Resident 94 was observed to have long, yellowish fingernails on both hands and with black residue observed under three fingernails on her left hand. Resident 94 stated fingernail care was not provided recently and wanted her fingernails to be cut and cleaned.A review of Resident 94's admission Record, dated January 8, 2026, indicated Resident 94 was admitted to the facility on [DATE], with diagnoses which included heart failure.A review of Resident 94's Care Plan, dated November 7, 2024, indicated, .Focus.at risk for skin breakdown.at risk for skin tears/skin injury R/T (related to) scratches self.age.fragile skin.Goal.Will remain free from tissue or skin injury.Interventions.keep fingernails clean and trimmed.A review of Resident 94's history and physical, dated November 28, 2025, indicated Resident 94 had the capacity to understand and make decisions.On January 7, 2026, at 12:42 p.m., a concurrent observation and interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated CNAs are responsible for providing fingernail care daily, which includes nail cutting, cleaning the surface and underneath the nails, and nail filing. CNA 1 stated fingernails should be cleaned and cut to prevent infections, especially when the residents use their hands to eat and grab items.On January 7, 2026, at 3:30 p.m., a concurrent observation and interview was conducted with the Director of Staff Development (DSD). The DSD stated Resident 94's fingernails were observed to be unkempt, yellowish, and with black residue underneath her fingernails. The DSD stated fingernail care should have been provided to Resident 94 and the fingernails should have been cleaned. The DSD stated this was important for infection control.On January 8, 2026, at 9:40 a.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 94's fingernails should have been cleaned and trimmed. The ADON stated it was important to perform fingernail care to reduce the risk for infection and self-injury.A review of the facility's policy and procedure titled, Fingernails/Toenail, Care of, dated February 2025, indicated, .Purpose.to clean the nail bed, to keep nails trimmed, and to prevent infections.Nail care includes daily cleaning and regular trimming.Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow the physician orders for oxygen administration, for two of two residents reviewed for oxygen (Residents 21 and 58), when:These failures had the potential to place Residents 21 and 58 at risk for adverse reactions from over-oxygenation.Findings:1.On January 5, 2026, at 3:06 p.m., an observation was conducted in Resident 21's room. Resident 21 was observed using oxygen at five (5) lpm (liters per minute - unit of measurement) via (through) a nasal cannula (NC).A review of Resident 21's admission Record, dated January 8, 2026, indicated the resident was admitted on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD - a lung condition making it difficult to breathe).A review of Resident 21's history and physical, dated March 17, 2025, indicated Resident 21 did not have the capacity to understand and make decisions.A review of Resident 21's Physician Orders, dated May 27, 2025, indicated, .OXYGEN VIA NC (nasal cannula) AT _3_LPM CONTINUOUSLY.A review of Resident 21's Care Plan, dated May 28, 2025, indicated, .Focus.The resident has asthma (a chronic inflammatory lung disease that causes recurring episodes of wheezing, coughing, shortness of breath, and chest tightness due to airway inflammation and narrowing) r/t (related to) COPD.Goal.remain free from complications.Interventions.Give.oxygen therapy as ordered.OXYGEN VIA NC as ordered.On January 5, 2026, at 3:25 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated Resident 21's oxygen flow rate was observed at five lpm. LVN 2 stated Resident 21's oxygen flow rate should have been at three lpm according to the physician's orders. LVN 2 stated it was important to follow the physician orders to prevent any adverse reactions from over-oxygenation.On January 8, 2026, at 9:52 a.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated Resident 21's oxygen flow rate should have been at three lpm according to physician's orders. The ADON stated it was important to follow physician orders to prevent respiratory issues related to increased oxygen rate, and to maintain the well-being of the resident.2. On January 5, 2026, at 2:55 p.m., an observation was conducted in Resident 58's room. Resident 58 was observed using oxygen at three lpm via nasal cannula.A review of Resident 58's admission Record, dated January 8, 2026, indicated the resident was admitted on [DATE], with diagnoses which included COPD.A review of Resident 58's history and physical, dated January 5, 2026, indicated the resident had the capacity to understand and make decisions.A review of Resident 58's Physician Orders, dated March 4, 2025, indicated, .OXYGEN VIA NC AT 2 LPM CONTINUOUSLY.A review of Resident 58's care plan, dated January 3, 2025, indicated, Focus.At risk for respiratory distress related to.COPD.Goal.no evident (sic) of respiratory distress.Interventions.Administer O2 (oxygen) as ordered.On January 5, 2026, at 3:27 p.m., a concurrent observation and interview was conducted with LVN 2. LVN 2 stated Resident 58's oxygen flow rate was observed at three lpm. LVN 2 stated Resident 58's oxygen flow rate should have been at two lpm according to the physician's orders. LVN 2 stated it was important to follow the physician's orders to prevent any adverse reactions from over-oxygenation.On January 8, 2026, at 9:54 a.m., an interview was conducted with the ADON. The ADON stated Resident 58's oxygen flow rate should have been at two lpm according to physician's orders. The ADON stated it was important to follow the physician's orders to prevent respiratory issues related to increased oxygen rate and to maintain the well-being of the residents.A review of the facility's policy and procedure titled, Physician Orders and Physician Notification, dated November 2025, indicated, .Orders shall be implemented.A review of the facility's document titled, Job Description, undated, indicated, .Charge Nurse.DUTIES AND RESPONSIBILITIES.Prepare and administer medications as ordered by the physician.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dietary staff were able to carry out the functions of food and nutrition services safely and effectively when: 1.Cook (CK) 1 did not know how to fully test the minced and moist texture (Minced & Moist foods are soft and moist but with no liquid that can leak or drip from the food and no crumbs), based on the standards of practice. This failure had the potential for risk of choking for six residents who had dysphagia (difficulty swallowing) and received minced and moist diet from the kitchen during the lunch meal on January 7, 2026.2. [NAME] (CK) 2 could not articulate the proper cool down process for ambient food (food kept at room temperature 70 F).3.A Dietary Aide (DA) did not follow manufacturer's guideline for the length of time for testing the red bucket Quaternary (Quat) sanitizer (sanitizing solution used for sanitizing food contact surfaces). These failures had the potential to cause foodborne illnesses for 111 residents who received food from the kitchen. Findings:1.According to standard of practice, the International Dysphagia Diet Standardization Initiative (IDDSI) Framework is a set of descriptors describing texture modified foods and thickened liquids for people with eating, drinking and swallowing problems across the lifespan.ˆ The Spoon Tilt Test is used predominantly for measures of food samples for Minced & Moist foods. Provides testing suggestions for exact sizes of food pieces consistent with a safe swallow based on research in children and adults. Added moisture is a must to make this level moist, cohesive, and not crumbly.On January 7, 2026, at 1: 23 p.m., during a concurrent interview and demonstration of how to test the right thickness and texture of minced and moist food, CK 1 could not show how the spoon tilt test was done. CK 1 further stated she did not know what spoon tilt test was. On January 9, 2026, at 11:07 a.m., an interview was conducted with the Registered Dietician (RD). The RD stated the cook should have known how to prepare and how to check the thickened liquids by using spoon tilt test if it is the right consistency for IDDSI diets. If not done correctly this could lead to difficulty chewing, difficulty swallowing and potential for choking. A review of the facility document titled, Minced And Moist, IDDSI (International Dysphagia Diet Standardization Initiative) . Tests.Critical: Spoon Tilt Test.Food slides off spoon with little food left on teaspoon. A review of the facility's undated Job Description titled, Cook, the Job Description indicated, Responsible for preparing food .in accordance with current applicable federal, state, and local standards .ESSENTIAL Functions: Ensure that all dietary procedures are followed in accordance with established policies.A review of the facility document titled, Minced And Moist, IDDSI (International Dysphagia Diet Standardization Initiative), . Tests.Critical: Spoon Tilt Test.Food slides off spoon with little food left on teaspoon. 2. On January 8, 2026, at 2:53 p.m. during an interview with CK 2, CK 2 stated cooling down is observed in the preparation of tuna salad. The tuna which is from a room temperature is cooled down to 40 F in two hours.On January 8, 2026, at 3:20 p.m. during an interview with the RD, the RD stated the cool down process from a temperature of 140 - 70 F for two hours, and then from 70 degrees F (Farenheit- unit of measurement for temperature) to 40 degrees F in the next four hours. The RD stated if the cooling down process was not followed, there was a potential for food to be in the food temperature danger zone and may result in food borne illness.A review of the facility document titled, Food Safety Inservice.Cooling Procedures., indicated, .Cooling procedures for Hot Foods.Improper cooling can lead to bacterial growth. The FDA Food Code requires that TCS (Time- Temperature Control for safety) foods to be cooled using a two-stage process.Stage one: cool from 135 F to 70 F within two hours. Stage two: Cool down from 70 F to 41 F or below within an additional four hours .3. On January 8, 2026, at 2:37 p.m., during a concurrent observation and interview, in kitchen with the DA, the DA tested the red bucket Quat sanitizer with a Quat sanitizer test strip. DA stated he needed to dip Quat sanitizer test strip into red bucket for 10 seconds. The DA only dipped Quat sanitizer test strip into red bucket for 6.9 seconds. The DA stated (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he should have followed what the instructions said, also saying, I should have waited for 10 seconds. The DA further stated if the instruction was not followed the right concentration of the sanitizer would not be accurate, leading to ineffective sanitization of work surfaces. On January 8, 2026, at 3:03 p.m., during an interview with the Dietary Services Supervisor (DSS), the DSS stated the dietary staff should have followed what was in the instructions for testing the red bucket Quat sanitizer. The DSS stated the Quat test strip was supposed to be dipped for 10 seconds. The DSS stated if Quat sanitizer test strip was dipped into the Quat sanitizer for a shorter length of time than the manufacturer's instructions, it could potentially lead to the dietary staff not getting the right concentration [NAME] sanitizer. The DSS stated if the [NAME] sanitizer was not in the right concentration, this could cause food contact surfaces to not be properly sanitized and lead to cross-contamination. A review of the Quat sanitizer test strip container's instructions, dated of July 30, 2026, indicated, Immerse for 10 seconds .