STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555390	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corona Regional Medical Center D/P Snf	730 Magnolia Avenue Corona, CA 92879

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the patients' rights were protected, specifically the right to have their designated representative informed of significant events or changes, for one of three residents reviewed (Resident 1), when the facility did not notify Resident 1's representative of the change in the prescription medication Tylenol #3 (acetaminophen-codeine, pain medication) to the prescription medication tramadol (pain medication).This failure prevented the residents' representative from participating in decisions related to the residents' care and well-being as authorized.Findings:On February 11, 2026, Resident 1's record was reviewed.Resident 1 was initially admitted to the facility on [DATE], with diagnoses including chronic respiratory failure (medical condition where the lungs cannot get enough oxygen into the blood) with hypoxia (low blood oxygen levels), tracheostomy (surgical opening in the neck to breath), gastrostomy (surgical opening into the stomach to insert a feeding tube), dependence on respiratory ventilator (inability to breath independently requiring mechanical assistance to get air in and out of the lungs), hemiplegia (paralysis on one side of the body), hemiparesis (weakness or paralysis on one side of the body), and vascular dementia (decline in thinking skills related reduce blood flow to the brain).Resident 1 was discharged from the facility to a GACH (General Acute Care Hospital) on May 25, 2025.The history and physical, dated May 23, 2024, indicated Resident 1 did not have the capacity to make decisions. The responsible party (RP) for Resident 1 was her daughter.The nursing note dated May 7, 2025, at 3:49 p.m., indicated MD (medical doctor) made rounds and ordered Tylenol #3 staff made aware.The physician order dated May 7, 2025, indicated the following: .Tramadol HCl Oral Tablet 50 MG (milligram - unit of measurement) (Tramadol HCl) Give 50 mg via G-Tube (gastrostomy tube) every 12 hours as needed for Moderate to severe pain (Pain scale 4-10 .) .Acetaminophen-Codeine Oral Tablet 300-30 MG (Tylenol #3) Give 1 tablet via G-Tube every 8 hours as needed for pain .The facility admission record indicated Resident 1 had allergies to hydrocodone (pain medication).On February 24, 2026, at 3:17 p.m., a concurrent interview and record review was conducted with the Registered Nurse (RN). The RN stated on the day the tramadol was ordered, Resident 1's RP was at her bedside when the physician was making rounds. The RN stated Resident 1's RP was the one who asked for her mother to be prescribed something for pain. The RN stated Resident 1's RP was informed by the physician of the order for the Tylenol #3. The RN stated the Tylenol #3 order was faxed to (named pharmacy) and the (named pharmacy) notified the RN that Resident 1 had an allergy to hydrocodone and Tylenol #3 was not recommended. The RN stated he contacted Resident 1's physician of her allergy to hydrocodone and the physician changed the order to tramadol 50mg. The RN stated Resident 1's RP was not notified of the change in medication from Tylenol #3 to tramadol and stated the RP should have been notified of the medication change.On February 24, 2026, at 3:23 p.m., a concurrent interview and record review was conducted with the Nurse Manager (NM). The NM stated the facility process is to inform the resident RP's of resident changes in condition, care, services, and transfers out of the facility. The NM stated the nursing staff should have informed Resident 1's RP of the change in medication from Tylenol #3 to tramadol 50 mg.The facility's policy and procedure titled, (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient's Rights and Responsibilities 1501, dated August 2024, was reviewed. The policy indicated .Informed participation in decisions regarding his/her care.The designation of a representative decision-maker in the event that a patient is unable to understand a proposed treatment or procedure or is unable to communicate his/her wishes regarding care.The hospital involves the patient in making decisions about his or her care, treatment, and services.the patient has the right to actively participate in decisions regarding his/her healthcare.The patient has the right to the information necessary to assist him/her to give informed consent or refuse the course of treatment.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Comprehensive Minimum Data Set (MDS - standardized assessment tool used to evaluate clinical, functional, and psychosocial status of all residents) Assessment accurately reflected the residents' current status for one of three residents reviewed (Resident 1), when discrepancies were found in Resident 1's Quarterly Comprehensive MDS Assessment.This failure had the potential to lead to inappropriate care planning for Resident 1.Findings:On February 11, 2026, Resident 1's medical record was reviewed.Resident 1 was initially admitted to the facility on [DATE], with diagnoses including chronic respiratory failure (medical condition where the lungs cannot get enough oxygen into the blood) with hypoxia (low blood oxygen levels), tracheostomy (surgical opening in the neck to breath), dependence on respiratory ventilator (inability to breath independently requiring mechanical assistance to get air in and out of the lungs), hemiplegia (paralysis on one side of the body), hemiparesis (weakness or paralysis on one side of the body), and vascular dementia (decline in thinking skills related reduce blood flow to the brain).Resident 1 was discharged from the facility to a GACH (General Acute Care Hospital) on May 25, 2025.The history and physical, dated May 23, 2024, indicated Resident 1 did not have the capacity to make decisions. The responsible party (RP) for Resident 1 was her daughter.The wound care note dated May 19, 2025, indicated .sacral fragile skin scar tissue reopening measuring 3 cm (a unit of measurement) length, 1 cm width, and 0.1 cm depth. Notified (named physician) with new order given.cleanse with normal saline pat dry apply traid cream (a sterile, zinc-oxide-based, paste used to treat pressure ulcers) cover with DD (dry dressing) for 30 days.The Quarterly MDS dated [DATE], indicated Resident 1 had no unhealed pressure ulcer (PU) injuries and was not receiving PU care.On February 18, 2026, at 10:00 a.m., a concurrent interview and record review was conducted with the Nurse Manager (NM). The wound care note dated May 19, 2025, was reviewed. The NM stated the wound care note indicated Resident 1 had a PU that reopened measuring 3 cm in length, 1 cm in width, 0.1 cm in depth with a physician order to clean with normal saline, apply triad and cover with a dry dressing for 30 days. The Quarterly MDS assessment dated [DATE], was reviewed. The NM stated the MDS assessment indicated Resident 1 had no PU and was not receiving PU care. The NM stated the MDS assessment did not reflect Resident 1's PU status and should have accurately reflected Resident 1's PU status. The NM further stated the facility follows the federal mandate for MDS assessments.A review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual MDS 3.0 RAI Manual, dated October 2018, indicated .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to ensure that a resident with a non-pressure related skin impairment received appropriate treatment and services in accordance with professional standards of practice for one of three residents reviewed (Resident 1), when the CNA (certified nurse assistant) failed to identify and report a left abdominal fold skin tear to the wound care nurse, resulting in a delay in treatment and increased risk of infection.This failure had the potential to cause a negative outcome in Resident 1's physical health.Findings:On February 17, 2026, Resident 1's medical record was reviewed.Resident 1 was initially admitted to the facility on [DATE], with diagnoses including chronic respiratory failure (medical condition where the lungs cannot get enough oxygen into the blood) with hypoxia (low blood oxygen levels), tracheostomy (surgical opening in the neck to breath), dependence on respiratory ventilator (inability to breath independently requiring mechanical assistance to get air in and out of the lungs), hemiplegia (paralysis on one side of the body), hemiparesis (weakness or paralysis on one side of the body), and vascular dementia (decline in thinking skills related reduce blood flow to the brain).Resident 1 was discharged from the facility to a GACH (General Acute Care Hospital) on May 25, 2025.The history and physical, dated May 23, 2024, indicated Resident 1 did not have the capacity to make decisions. The responsible party (RP) for Resident 1 was her daughter.The I View and O (a section of the Electronic Medical Record used for real time patient assessments and interventions) completed by the Certified Nurse Assistant (CNA) dated May 25, 2025, indicated Resident 1 had a complete linen change, face care, peri care (washing the genital and anal area), and a shower.The physician order dated May 25, 2025, at 6:02 p.m., indicated .transfer patient (Resident 1) to ER (emergency room) due to seizure (sudden burst of electrical activity in the brain), hypertension (high blood pressure), and tachycardia (fast heart rate).The (name of GACH ER) photograph dated May 25, 2025, at 8:14 p.m., indicated an unnamed skin tear covered with a white cream on an unnamed part of the body.On February 17, 2026, at 9:55 a.m., a concurrent interview and record review was conducted with the skilled nursing facility (SNF) CNA/RNA (restorative nurse assistant - a certified nurse assistant who provides rehabilitation care and services) assigned to Resident 1. The RNA stated the facility process is for CNAs to perform skin checks when performing incontinent care (care giving after experiencing involuntary loss of bladder or bowel), bed baths, showers, and report abnormal findings or significant changes in the skin to the wound care nurse or charge nurse. The RNA reviewed the I View and O dated May 25, 2025, at 10:00 a.m., and stated she assisted the (named CNA) with showering Resident 1 on May 25, 2025, at 10:00 a.m. The RNA stated she performed a skin check on Resident 1 during her shower. The RNA stated there were no abnormal findings from Resident 1's skin check to report to the wound care nurse. The RNA stated she applied triad barrier cream (sterile, zinc-oxide-based, paste used to protect skin from moisture) to Resident 1's abdominal folds. The RNA reviewed the photo taken at (named GACH ER). The RNA stated the photo dated May 25, 2025, at 8:14 p.m., indicated a skin tear of an unknown body part covered with barrier cream. The RNA stated the skin tear indicated in the (named GACH ER) photo would be considered an abnormal finding reportable to the wound care nurse. The RNA stated she did not identify the skin tear in the named hospital photo when giving Resident 1 a shower. On February 25, 2025, at 3:53 p.m., a telephone interview was conducted with the GACH Wound/Ostomy Nurse ([NAME]). The [NAME] stated the facility process upon admission the floor nurse will assess the residents' skin and photograph any abnormalities. The [NAME] stated Resident 1 was admitted into the (second named GACH) on May 26, 2026, at 2:40 a.m., and the floor nurse photograph Resident 1's left abdominal fold skin tear. A concurrent review was conducted of the photo dated May 26, 2026, at 2:40 a.m. The [NAME] stated the picture indicated a left abdominal fold skin tear. The [NAME] stated Resident 1 arrived to (second named GACH) with the left abdominal fold skin tear. The [NAME] stated after reviewing Resident 1's left abdominal fold skin tear picture she informed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's assigned nurse to apply a hydrofiber with silver (wound care product that transform into gel upon contact with wound fluid) to the left abdominal fold skin tear.On March 2, 2026, at 11:39 a.m., a concurrent interview, and record review was conducted with the SNF Nurse Manager (NM). The NM stated the CNAs are to perform skin checks during incontinent care, bed baths, showers, and report abnormal findings to the wound care nurse. The NM stated it is the facility's standard to apply traid barrier cream to areas of the resident that accumulate moisture. The NM reviewed the photo taken at the (named GACH ER). The NM stated the photo dated May 25, 2025, at 8:16 p.m., indicated a skin tear of the abdominal fold covered with barrier cream. The NM reviewed the (second named GACH) photo dated May 26, 2025, at 2:40 a.m. The NM stated the photo indicated a left abdominal skin tear. The NM stated the CNAs should have identified the left abdominal skin tear during the shower on May 25, 2025, at 10 a.m., and reported the abnormal finding to the wound care nurse.A review of the job description titled, Nursing Asst (CERT), revised March 4, 2026, indicated .Essential Job Duties and Responsibilities.Notifies the license nurse for any noticeable changes in the patients/resident's medical condition.Monitors patient/residents' safety and immediately reports concerns to the licensed nurse.A review of the facility policy and procedure titled, Skin Care and Prevention of Pressure Injury, dated July 2025, indicated .To provide guidelines for assessment, interventions, documentation, and management of patient's skin.Routinely assess.the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the Interdisciplinary Team (IDT - a collaborative group of diverse healthcare professionals who work together to create and implement a unified, comprehensive care plan for a resident) notes accurately reflected the residents' current status for one of three residents reviewed (Resident 1), when discrepancies were found in Resident 1's IDT Notes.This failure had the potential to lead to improper care planning and inaccurate communication between disciplines.Findings:On February 11, 2026, Resident 1's medical record was reviewed.Resident 1 was initially admitted to the facility on [DATE], with diagnoses including chronic respiratory failure (medical condition where the lungs cannot get enough oxygen into the blood) with hypoxia (low blood oxygen levels), tracheostomy (surgical opening in the neck to breath), and dependence on respiratory ventilator (inability to breath independently requiring mechanical assistance to get air in and out of the lungs).Resident 1 was discharged from the facility to a GACH (General Acute Care Hospital) on May 25, 2025.The IDT Monthly Meeting Notes for the months of November 2023; December 2023; February 2024 - June 2024; August 2024 - December 2024; and January 2025 - May 2025, were reviewed and indicated .restraints.two bedrails raised and locked while in bed for seizure activity and whole body jerking while coughing or while being suctioned.There was no documented evidence that Resident 1 had a diagnoses of seizures.On February 18, 2026, at 10:00 a.m., a concurrent interview and record review was conducted with the Director of Subacute (DS) and the Nurse Manager (NM). The IDT Monthly Meeting Notes for the following months were reviewed: November 2023; December 2023; February 2024 - June 2024; August 2024 - December 2024; and January 2025 - May 2025. The NM stated there was no documented evidence of Resident 1's seizure diagnosis from admission [DATE]) to discharge (May 2025).The DS stated the IDT Monthly Meeting Notes inaccurately reflected Resident 1's restraint usage by citing a diagnosis of seizures, rather than noting two locked bed rails for ventilator-dependent whole body jerking while coughing or while being suctioned. The DS further stated the MDS nurse failed adequately customize the IDT Monthly Meeting Notes to reflect Resident 1's correct diagnosis resulting in documentation that did not accurately reflect the resident's specific clinical or functional status.A review of the facility policy and procedure titled, Medical Record Content & Documentation, revised June 20, 2025, indicated .Purpose.To ensure correct documentation for patient safety.Medical Records must be completed accurately.