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	03/12/2026

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

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician's orders were followed for two of three residents, Residents 1 and 2, when:Resident 1 did not have hand rolls in her left and right hands; andResident 2 did not have a left elbow splint.These failures had the potential to result in Residents 1 and 2 having skin impairments and further decline in range of motion.Findings:1.A review of Resident 1's electronic medical record indicated the resident was initially admitted to the facility on [DATE], with diagnoses which included respiratory failure (a serious condition that happens when the lungs cannot get enough oxygen into the blood).A review of Resident 1's Minimum Data Assessment (MDS - an assessment tool) dated July 3, 2025, indicated the resident has functional limitations in range of motion to her left and right, upper and lower extremities.A review of Resident 1's Order Summary Report dated March 11, 2026, indicated the following were ordered by the physician on March 13, 2025:-left towel roll in hand every day shift; and-right towel roll in hand every day shift.On March 11, 2026, at 10:23 a.m., during a concurrent observation and interview, Resident 1 was lying in bed with head of bed elevated at least 30 degrees, eyes were closed, non-verbal and she had a tracheostomy tube (an artificial airway to help a person breathe, remove mucus, or deliver oxygen directly to the lungs) connected to oxygen. Resident 1's upper extremities were flexed on her chest, and her left and right hands did not have hand rolls.On March 11, 2026, at 2:39 p.m., during a concurrent observation of Resident 1 and interview with the Restorative Nursing Assistant (RNA), Resident 1 did not have towel rolls in her left and right hands. The RNA stated Resident 1 was supposed to have towel rolls in each of her hands. The RNA stated she gave Resident 1 a shower that morning and forgot to place the towel rolls in each of her hands. The RNA stated she was responsible for placing the towel rolls in Resident 1's hands.2. A review of Resident 2's electronic medical record indicated Resident 2 was initially admitted to the facility on [DATE], with diagnoses which included respiratory failure. A review of Resident 2's MDS dated September 23, 2025, indicated the resident has functional limitation of range of motion to his left and right, upper and lower extremities. A review of Resident 2's Order Summary Report dated March 11, 2026, indicated the following was ordered on November 25, 2025: -RNA/ nursing manage left elbow extension splint (a medical device used to support, protect, and immobilize the elbow) up to four hours as tolerated daily every day shift. On March 11, 2026, at 10:54 a.m., during an observation, Resident 2 was in his room, lying in bed with head of bed elevated at least 30 degrees, alert, non-verbal, with tracheostomy tube connected to oxygen. Resident 2's left upper extremity was extended by his left side with no splint. On March 11, 2026, at 2:36 p.m., during a concurrent observation of Resident 1 and interview with the RNA, Resident 1 did not have a left elbow splint. The RNA stated she was not aware Resident 1 had a left elbow splint. The RNA stated they keep all splints for Resident 1 in the mesh bag and there was no elbow splint in there. On March 12, 2026, at 4:08 p.m., during a concurrent interview with the Director of Nursing (DON) and record review of Resident 2's medical record, the DON stated the RNA should follow the doctor's order and apply the left elbow splint for Resident 2. A review of the facility's policy and procedure titled, Restorative (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant Program dated July 2025, indicated, The facility is responsible for providing maintenance and restorative programs .to achieve and maintain the highest practicable outcomes .The Restorative Nursing Assistant carries out the programs according to the written plan of care and documents it daily .Restorative Nursing Responsibility . splinting, application of orthotics and Braces (sic)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the medications were administered within 60 minutes of their scheduled times for one resident, Resident 3.This failure had the potential to result in decreased effectiveness of Resident 3's medications.Findings:On March 11, 2026, at 11:18 a.m., during a medication pass (med pass) observation and interview with Licensed Vocational Nurse (LVN) 1, LVN 1 prepared the following medications for Resident 3:-ascorbic acid (Vitamin C) 500 mg for supplement;-benztropine mesylate (Cogentin) 0.5 mg for muscle spasm;-cranberry 250 mg for urinary tract infection prophylaxis;-esomeprazole 40 mg for gastrointestinal prophylaxis;-lactobacillus for supplement;-multivitamin and mineral 15 ml for supplement; and-quetiapine (Seroquel) 100 mg for generalized anxiety. During the same observation, LVN 1 administered these medications at 12:08 p.m., to Resident 3 via gastric tube (a soft, flexible tube inserted directly through the skin of the abdomen into the stomach). LVN 1 stated Resident 3's medications were scheduled for 10:00 a.m.A review of Resident 3's face sheet indicated she was admitted to the facility on [DATE], with diagnoses which included respiratory failure.A review of Resident 3's Order Summary Report dated March 11, 2026, and Medication Administration Record for the month of March 2026, indicated Resident 3 had the following medications scheduled to be administered at 10:00 a.m.:-ascorbic acid 500 mg for supplement;-benztropine mesylate 0.5 mg for muscle spasm;-cranberry 250 mg for urinary tract infection prophylaxis;-esomeprazole 40 mg for gastrointestinal prophylaxis;-lactobacillus for supplement;-multivitamin and mineral 15 ml for supplement; and-quetiapine 100 mg for generalized anxiety.On March 11, 2026, at 1:09 p.m., during an interview, LVN 1 stated they have one hour before and one hour after the scheduled time to administer residents' medications. LVN 1 stated for the 10:00 a.m., med pass, they have between 9:00 a.m., to 11:00 a.m., to administer the residents' medications. LVN 1 stated he was behind on med pass because he attended to other residents who needed a dressing change and as needed medication. LVN 1 stated if he is getting behind with med pass, he would talk to the other licensed nurses to help him out, but they were all busy.On March 12 at 4:08 p.m., during an interview with the Director of Nursing (DON), the DON stated the licensed nurses were expected to administer medications one hour before and one hour after the scheduled time. A review of the facility's policy and procedure, titled, Medication Administration - General Guidance dated July 2025, indicated .Medications are administered within one hour before and one after the scheduled time, except for orders relating to before, after and during meal orders. Which are administered as ordered (sic) Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility .