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	05/23/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure services provided meet professional standards of practice, for one of one resident reviewed (Resident 39), when the Licensed Vocational Nurse (LVN) did not check the NGT (nasogastric tube - a flexible tube inserted through the nose and down the throat into the stomach) placement prior to medication administration. This failure had the potential for Resident 39 to develop aspiration pneumonia (a lung infection that occurs when food, liquid, or objects are inhaled into the lungs causing inflammation and fluid build-up). Findings: On May 21, 2025, at 11:23 a.m., a concurrent medication administration observation and interview was conducted with the LVN. The LVN was observed to prepare Resident 39's medications and checked the arm band to verify her identity. The LVN stopped the feeding, attached a 60 ml (milliliter - a unit of measurement) syringe into the NGT and tried to aspirate for gastric residual (stomach contents). There was no gastric residual observed after the LVN aspirated from the NGT. The LVN was observed to pour the medications into the 60 ml syringe. The LVN was asked prior to administering the medication if she checked the NGT placement. The LVN stated there was no need to check the tube placement since Resident 39 had NGT and not a G-tube (gastrostomy tube - a medical device inserted through the abdominal wall directly into the stomach, used to provide enteral nutrition or medications). The LVN was instructed to check NGT placement prior to medication administration. Resident 39's record was reviewed. Resident 39 was admitted to the facility on [DATE], with diagnoses which included post partum cardiac arrest (a sudden, unexpected loss of heart function, breathing and consciousness after giving birth). Resident 39's care plan, dated January 9, 2025, indicated, .Resident has NGT .The resident will be free of aspiration .Check for tube placement and gastric contents/residual volume per facility protocol . (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 21, 2025, at 3:18 p.m., the Director of Nursing (DON) was interviewed. The DON stated all licensed nurses (LVN or Registered Nurse) were expected to check tube placement, NGT or G-tube prior to administering tube feedings and/or medications. The DON stated placement verification of the tube could be done by aspirating for gastric residual. He stated if there was gastric residual, the tube was in place. He stated if there was no gastric residual, the licensed nurse should slowly inject a small amount of air using a 60 ml syringe into the tube and listen with the use of a stethoscope for the swooshing sound to verify placement. The DON stated the LVN should have checked the NGT placement by slowly injecting a small amount of air into the tube and listened to the swooshing sound before administering medications. A review of the facility's policy and procedure titled, Medication Administration Through an Enteral Tube, reviewed April 2024, indicated, .Verify placement of the Nasogastric tube or Gastrostomy tube by either one or both procedure .Attach the syringe to the feeding tube and try to aspirate stomach contents .Place the stethoscope just below the xiphoid process (pointed end at the bottom of the breastbone) and instill 10-25 ml of air on (sic) the feeding tube. Listen for gurgling or whooshing sound, which indicates proper placement .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 15 vials of Ativan (medication used to treat anxiety disorders) two (2) mg (milligram - a unit of measurement) was not stored beyond the manufacturer's recommended discard date during an inspection of the medication refrigerator in the medication storage room located in the main building. This failure had the potential for a resident to receive an expired and ineffective medication. Findings: On [DATE], at 2:12 p.m., a medication storage room inspection was conducted with the Nurse Manager (NM). One vial of Ativan 2 mg with an expiration date of [DATE], was found stored in the medication refrigerator in the medication storage room located in the main building. In a concurrent interview with the NM, she stated any expired medication should be removed from use to prevent a licensed nurse from administering to a resident. On [DATE], at 3:18 p.m., the Director of Nursing (DON) was interviewed. The DON stated the staff checked the medications for expiration date and failed to see the expired Ativan 2 mg vial. The DON stated the expired medication should have been removed from use and returned to the pharmacy. A review of the facility's policy and procedure titled, Medication Storage, reviewed [DATE], indicated, .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure expired food items were not stored in the refrigerator, readily available for use. This failure had the potential to result in foodborne illness to a vulnerable facility population. Findings: On May 19, 2025, at 7:15 a.m., an initial tour of the kitchen was conducted with the Director of Nutritional Services (DNS). Two fruit cups labeled with a use-by date of May 18, 2025, were observed in the refrigerator, readily available for use. One fruit cup with no label or date was also observed in the refrigerator, readily available for use. On May 19, 2025, at 7:15 a.m., a concurrent interview and record review was conducted with the DNS. The DNS stated all items stored in the refrigerator should have a use-by date. The DNS stated the one fruit cup with no label or date should not have been stored in the refrigerator, readily available for use. The DNS stated the two fruit cups should have been discarded on or before the expiration date (use-by date), and not stored in the refrigerator, readily available for use. A list of residents on an oral diet (food and drink consumed by mouth) indicated two residents out of the 60 residents in the facility were on an oral diet. A review of the facility policy and procedure, titled, Food Storage, revised January 2020, was reviewed. The policy and procedure indicated, .The Nutritional Service Department assures that safe, sanitary food storage . for a variety of food forms occurs in a strictly defined manner .All .prepared salads are covered, labeled, and dated with use by date and placed in refrigerator until further use .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control practice was implemented when the Licensed Vocational Nurse (LVN) did not properly clean and disinfect shared glucometer (measures the amount of glucose [sugar] in the body) in accordance with the disposable wipe manufacturer's specified contact time (contact time/wet time - amount of time a disinfectant needs to stay visibly wet on a surface to effectively kill germs). This failure had the potential to expose the resident to cross-contamination and development of infection. Findings: On May 21, 2025, at 12:08 p.m., during a medication administration observation with the LVN, the LVN was observed using a shared glucometer. The LVN was observed to wipe the glucometer with a Sani cloth disposable wipe (used to clean, sanitize and disinfect hard, non-porous surfaces [does not allow liquid or air to pass through it])) then proceeded to check Resident 18's blood sugar. The LVN was observed to wipe the glucometer with a Sani cloth disposable wipe but did not follow the manufacturer's specified contact time of two (2) minutes. On May 21, 2025, at 12:28 p.m., during an interview with the LVN, she stated she used the Sani cloth disposable wipe to sanitize the glucometer before and after each use and allowed to air dry. She stated the glucometer was wet but not for 2 minutes. The LVN stated she did not follow the contact time of 2 minutes as per manufacturer's instructions. On May 21, 2025, at 12:41 p.m., the Director for Staff Development (DSD) and the Director of Nursing (DON) were interviewed. The DSD and the DON stated the licensed nurse should sanitize the glucometer before and after use with the Sani cloth wipes. The DSD and DON stated the manufacturer's instructions for 2 minutes contact time should be followed by the staff. A review of the facility's policy and procedure titled, Disinfecting Patient Equipment, reviewed June 2024, indicated, .All patient care equipment is cleaned and disinfected .All patient care items are disinfected between patient use by point of care staff (Nursing, Transporters, Ancillary, etc.) .Manufacturer's instructions for use of each product are followed . A review of the manufacturer's instructions for Sani wipes indicated, .Contact time .thoroughly wet surface. Allow surface to remain wet for two (2) minutes, let air dry .