STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555566	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corona Post Acute Center	2600 South Main Street Corona, CA 92882

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 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** 41348 Based on observation, interview, and record review, the facility failed to provide care and services for activities of daily living (ADLs), for one of three sampled residents (Resident 1), when feeding assistance was not provided according to the physician's orders and plan of care. This failure had the potential to negatively affect the resident's physical well-being and lead to continued weight loss. Findings: On April 17, 2024, at 10:25 a.m., an unannounced visit was conducted at the facility for a complaint. On April 17, 2024, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal sugar in the blood), and dementia (memory loss that affects thinking and can interfere with daily functioning). Resident 1's History and Physical, dated December 3, 2023, indicated Resident 1 had fluctuating capacity to understand and make decisions. Review of Resident 1's Order Summary, included a physician's order, dated April 1, 2024, which indicated, . RNA (Restorative Nurse Assistant - has had special training in performing tasks that restore or maintain physical function) Program Feeding for breakfast, lunch, and dinner . Review of Resident 1's weights indicated Resident 1 weighed 121 pounds on March 5, and weighed 116 pounds on April 5, 2024, a weight loss of five pounds in a month. Review of Resident 1 ' s Tasks, during April 1-16, 2024, indicated the following: - Resident 1 consumed 0 - 25% of her meals most of the time, with some episodes of refusals; and - Resident 1 was provided set up or clean up assistance most of the time during for meals. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Nutritional Care, dated April 9, 2024, at 1:39 p.m., indicated, .Avg (average) PO (oral) intake 33% x 21 meals .multiple interventions in place to aid weight maintenance .on RNA feeding program as of 4/4/24 to aid increase PO intake. Noted encouragement and cueing to be provided during meals . On April 17, 2024, at 12:39 p.m., staff were observed passing lunch trays. On April 17, 2024, at 12:52 p.m., Resident 1 was observed sitting up in bed eating lunch, no staff were observed at bedside. Resident 1 stated lunch was good today. On April 17, 2024, at 1:06 p.m., Certified Nursing Assistant (CNA) 1 was observed collecting trays from the resident rooms. During a concurrent interview, CNA 1 stated she provided care to Resident 1. CNA 1 stated Resident 1 ate independently. CNA 1 stated Resident 1 ate very little. CNA 1 stated Resident 1 would benefit from RNA feeding assistance to increase her meal intake. CNA 1 stated when she was able, she would encourage Resident 1 to eat but did not assist her with eating. On April 17, 2024, at 1:15 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated when residents had an order for RNA feeding, the RNAs would take the residents to the dining room for assistance. LVN 1 stated when the resident was not able to go to the dining room, the CNAs were responsible for bedside feeding assistance. LVN 1 stated it was important for the CNA to remain at bedside to encourage meal intake and to assist as needed to help prevent weight loss. On April 17, 2024, at 1:20 p.m., an interview was conducted with the Treatment Nurse (TxN). The TxN stated when residents were on the feeding program, they were assisted to the dining room. The TxN stated when the resident was unable to go to the dining room staff should assist with feeding at the bedside. During a concurrent record review of Resident 1's medical record, the TxN stated Resident 1 had lost 5 pounds in one month. The TxN stated Resident 1 had an order for RNA feeding assistance for breakfast, lunch, and dinner. The TxN stated Resident 1 did not go to the dining room for meals and should have staff assistance at bedside. The TxN stated the tasks indicated most meals Resident 1 ate only 0-25%, and staff assisted with set-up and clearance and not supervision as ordered. The TxN stated Resident 1's intake was poor and feeding assistance should be done as ordered to prevent further weight loss. On April 17, 2024, at 1:56 p.m., an interview was conducted with LVN 2. LVN 2 stated when a resident was ordered RNA feeding, the resident would be taken to the dining room. LVN 2 stated when the resident was unable to go to the dining room, staff should provide feeding assistance at bedside. LVN 2 stated setting up the meal tray and leaving would not be feeding assistance. LVN 2 stated Resident 1 ate in her room and did not go to the dining room. During a concurrent record review of Resident 1's medical record, LVN 2 stated Resident 1 had an order for RNA feeding for all meals written on April 1, 2024. LVN 2 stated there was no documentation to indicate Resident 1 had received feeding assistance and most documentation indicated Resident 1 had meal set-up and clearance only. LVN 2 stated Resident 1 had weight loss and it was important for her to have feeding assistance to prevent further weight loss. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 17, 2024, at 2:21 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated RNA feeding was done in the dining room, when residents were unable to go to the dining room expectations from staff were that they remained at the residents' bedside for meals for cueing, encouragement, and assistance as needed. The DSD stated Resident 1 had weight loss and RNA feeding was ordered. The DSD stated staff discussed her needs, and it was determined that she needed staff at bedside to encourage her to eat her meals. The DSD stated staff should stay at Resident 1's bedside to increase her meal intake, not open the meal tray and leave. On April 17, 2024, at 2:55 p.m., Resident 1 was observed sleeping, Resident 1's family member (FM) was observed sitting at bedside. During a concurrent interview, the FM stated several times she had come to visit and had seen Resident 1's meal tray opened on the overbed table, and no staff were present. The FM stated staff just uncovered the meal and left the room and did not return. The FM stated she would assist Resident 1 with meals when able but was not always at the facility during mealtimes. The FM stated Resident 1 had lost weight and needed encouragement to eat. On April 17, 2024, at 3:10 p.m., an interview was conducted with the interim Director of Nursing (iDON). The iDON stated when residents were put on the RNA feeding program, they would be assisted to the dining room or staff would remain at bedside to assist with meals. The iDON stated it was not acceptable to open a meal tray and leave the resident without providing assistance as ordered. During a concurrent record review of Resident 1's medical record, the iDON stated Resident 1 had RNA feeding ordered on April 1, 2024, for weight loss. The iDON stated the documentation indicated most meals provided to Resident 1 were documented as set-up and clearance only and not supervision or assistance as ordered. The iDON stated Resident 1 had poor oral intake and consumed only 25% of most meals. The iDON stated Resident 1 should have the RNA feeding assistance as ordered to prevent further weight loss. Review of the facility document titled, Restorative Dining Program, dated April 1, 2023, indicated, .To provide the opportunity for residents to attain their highest level of independence in feeding, improve appropriate mealtime behavior .A resident may be included in the Restorative Dining Program if the resident is unable to feed themselves due to physical limitations .Objectives .Facilitate maximum potential in feeding .Assistance required .Physical Prompt: Hand over hand .Verbal Cues . Review of the facility document titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .including appropriate support and assistance with .Dining (meals and snacks) .