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	12/13/2024

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 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** 44505 Based on interview and record review, the facility failed to reassess the vital signs, including blood pressure, for one of three sampled residents (Resident 1). This failure had the potential to delay the staff from acting promptly if the blood pressure remained persistently low which could lead to complications such as confusion, fainting, and organ damage. Findings: On November 22, 2024, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included sepsis (a life-threatening complication of an infection) and enterocolitis (inflammation that occurs throughout the intestines). A review of Resident 1's document titled, Change of Condition dated November 5, 2024, indicated, .The change in condition .Abnormal vital signs .Vital Signs Evaluation .Blood Pressure: 65/49 .New irregular pulse . A review of Resident 1's progress notes dated November 5, 2024, indicated, .21:00 (9 p.m.) Checked vital signs and noticed BP (blood pressure) was 65/49 .received order to transfer to (sic) out to (name of the hospital) for further evaluation .(name of transport) arrived 10:30pm (one and a half after) . Further review of Resident 1's progress notes dated November 5, 2024, indicated there was no documentation of the resident being reassessed or monitored after the initial blood pressure reading of 65/49, while waiting to be transferred to the hospital. On November 22, 2024, at 3:50 p.m., during a concurrent interview and review of Resident 1's progress notes dated November 5, 2024, with the Director of Nursing (DON), the DON stated since Resident 1's blood pressure was low, the licensed nurse should have reassessed or rechecked the resident's blood pressure and documented it in the progress notes. The DON stated there was no documentation that the licensed nurse rechecked the resident's blood pressure. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 22, 2024, at 12:22 p.m., Licensed Vocational Nurse 1 (LVN 1) was interviewed. LVN 1 stated the family member reported that the resident did not look good. LVN 1 stated she went to check on the resident and took his vital signs. LVN 1 stated Resident 1's blood pressure was low. LVN 1 stated she referred the resident to the RN Supervisor. LVN 1 stated she did not recheck the blood pressure after the initial low reading of 65/49. LVN 1 stated, she should have rechecked Resident 1's blood pressure as the reading was low and could get lower. On November 22, 2024, at 3:55 p.m., Registered Nurse 2 (RN 2) was interviewed. RN 2 stated Resident 1 went to the hospital due to low blood pressure. RN 2 stated when a resident had low blood pressure, the blood pressure should be reassessed, and interventions should be provided. RN 2 stated there should be documentation of the interventions provided to the resident. RN 2 stated there was no documentation indicating that the resident was reassessed and monitored or that interventions were provided. A review of the facility policy and procedure titled, Change in a Residents Condition or Status, dated February 2021, indicated, .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview and record review, the facility failed to implement infection control practices when disposable equipment, including a stethoscope (a medical instrument) and sphygmomanometer (blood pressure machine), was not readily available for one of one sampled resident (Resident 1) with Clostridium Difficile (C. diff - a highly contagious bacteria). This failure increased the risk of spreading infection to other residents and staff. Findings: A review of Resident 1's Admission Record indicated Resident 1 was readmitted to the facility on [DATE], with diagnoses which included enterocolitis (inflammation of the digestive tract) due to clostridium difficile. Resident 1 was placed on contact precautions. On November 21, 2024, at 11:20 a.m., a concurrent observation and interview with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 1 was on isolation due to C. diff. Outside Resident 1's room, an isolation cart was observed with personal protective equipment (gowns, face shield, and masks). CNA 1 stated, there was no disposable blood pressure cuff or stethoscope available. CNA 1 stated, there should be a disposable stethoscope and blood pressure machine designated for the resident in isolation. On November 21, 2024, at 11:38 a.m., during an interview with Registered Nurse 1 (RN 1), RN 1 stated, the isolation cart should contain disposable supplies, including a stethoscope and a blood pressure machine, readily available for the resident. On November 21 ,2024 at 2:18 PM, during an interview with the Infection Preventionist (IP), the IP stated Resident 1 was on contact precaution, and the isolation kit should have disposable equipment available to allow staff to perform their duties properly. On November 21, 2024, at 3:38 PM, during an interview with the Director of Nursing (DON), the DON stated isolation patients with C. diff should preferably have designated equipment to ensure proper infection control. A review of the facility Policy and Procedure titled, Clostridium Difficile, dated October 2018, indicated, . measure is taken to prevent the occurrence of Clostridium difficile infections among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to others .the primary reservoirs for C. difficile are infected people and surfaces. Spores can persist on resident-care items and several surfaces for several months and are resistant to some common cleaning and disinfections methods . A review of the facility policy and procedure titled, Isolation-Categories of Transmission Based Precautions, dated September 2022, indicated, .when transmission-based precautions are in effect, non-critical resident care equipment items such as stethoscope, sphygmomanometer, or digital thermometer will be dedicated to a single resident (or cohort of residents) when possible .