

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/22/2025
NAME OF PROVIDER OR SUPPLIER  Corona Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0562</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide immediate access to any resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure telephone calls for the resident were answered by the facility staff for one of three residents reviewed (Resident A).</p> <p>This failure had the potential to lead to physical and psychosocial distress for Resident A.</p> <p>Findings:</p> <p>On March 26, 2025, at 10:10 a.m., an unannounced visit to the facility was conducted to investigate a quality of care issue.</p> <p>On March 26, 2025, at 2:30 p.m., during an interview with Resident A and Resident A's Family member (FM), Resident A stated, her call light had fallen to the floor. She stated, she began hollering out for staff assistance, but no one came into the room. Resident A stated she called a family member for help. Resident A's FM stated, she had experienced issues with the facility's phone systems. She stated, she attempted to call the facility multiple times from 9:11 p.m to 9:22 p.m. but received no response. Resident A's FM stated, the phone was answered after 9:22 p.m., was transferred to the nurses station but the call was not answered and did not receive a callback from staff. She stated, she expressed frustration over the lack of communication.</p> <p>On March 28, 2025, at 5:20 p.m., during an interview with the Facility Receptionist (FR), she stated she remained at the facility until 9 p.m., after which incoming calls were transferred to the Registered Nurse Supervisor (RNS).</p> <p>On March 28, 2025, at 5:30 p.m., during an interview with the RNS, she stated when she was attending to a change in resident's condition or administering medication, it would be possible that phone calls may not be answered immediately.</p> <p>A review of Resident A's Admission Record indicated, Resident A was admitted to the facility on [DATE], with diagnoses which included ALS (Amyotrophic Lateral Sclerosis- a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord, leading to muscle weakness and eventually paralysis).</p> <p>On March 28, 2025, at 5:34 p.m, Resident B was interviewed, she stated calls that were intended for her were never forwarded to her.</p> <p>(continued on next page)</p>

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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<p>F 0562</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On March 28, 2025, at 5:36 p.m, Resident C was interviewed, he stated calls that were intended for him were never forwarded to him.</p> <p>On April 10, 2025, at 2 p.m., during an interview with the Administrator, she stated the expectation was for the calls made during office hours and after office hours</p> <p>will be forwarded to the right person and will be answered by staff.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038</b></p> <p>Based on interview and record review, the facility failed to ensure that Hydrocodone (a strong pain medicine) was reordered in a timely manner for one of three sampled residents (Resident A), resulting in the medication not available when needed.</p> <p>This failure had the potential for Resident A's pain to be uncontrolled and not following the physician-ordered pain management regimen.</p> <p>Findings:</p> <p>On March 26, 2025, at 10:10 a.m., an unannounced visit to the facility was conducted to investigate a quality of care/treatment issue.</p> <p>A review of Resident A's Admission Record, indicated Resident A was admitted to the facility on [DATE], with diagnoses which included spinal stenosis lumbosacral region ( refers to a narrowing of the spinal canal in the lower back, which can put pressure on the spinal cord [A column of nerve tissue that runs from the base of the skull down the center of the back ] and nerve roots, potentially causing pain, numbness, and weakness).</p> <p>A review of Resident A's progress notes titled, Medication Administration Note, dated February 24, 2025, indicated, Hydrocodone 5-325 was not administered due to medication not available.</p> <p>On March 28, 2025, at 2 p.m., during a concurrent interview and review of Resident A's progress note on medication administration with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the Hydrocodone 5- 325 was not available. The LVN stated routine pain medication should be reordered when there were seven pills remaining in the medication card. The LVN stated there was no documentation showing that the medication had been reordered when only seven pills remained. LVN 1 sated she should have reordered the medication to ensure continued availability.</p> <p>On March 28, 2025, at 2:45 p.m., during a concurrent interview and record review with the Registered Nurse Supervisor, (RNS), the RNS stated the Hydrocodone was unavailable and there was no documentation of a timely reorder three to four days before the medication ran out. She stated the licensed nurses were expected to reorder medication when approximately seven tablets remain.</p> <p>A review of facility policy and procedure titled, Medication Orders and Receipt Records, dated April 2007 indicated, .Medication should be ordered in advance .</p>