| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555566 | A. Building<br>B. Wing | 05/13/2025 |

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

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for three of three sampled residents (Residents 1, 4, and 6), the facility failed to ensure appropriate assessment, monitoring, and a follow-up evaluation of skin conditions and injuries were conducted when:<br><br>1. For Resident 1, the treatment for a burn injury was not initiated or monitored upon return from the hospital on April 10, 2025. In addition, a follow-up appointment for evaluation of the burn injury was not arranged;<br><br>2. For Resident 4, a new skin injury (bruising [skin discoloration] to the left and right hands) identified by the Certified Nursing Assistant (CNA) on April 27, 2025, was not addressed or referred to the physician for appropriate care and treatment. In addition, the licensed nurse did not conduct an ongoing skin assessment, monitored the injury, or evaluated the resident for potential complications after the skin injury was noted;<br><br>3. For Resident 6, a change in condition related to a known foot injury was not identified and communicated to the physician for appropriate care and treatment.<br><br>These failures had the potential to delay necessary care and treatment, increasing the risk of complications related to skin injuries and other skin-related conditions.<br><br>Findings:<br><br>1. On May 7, 2025, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnosis of metabolic encephalopathy (a brain disorder that results from a disturbance in metabolism, causing brain dysfunction) and diabetes (inability to regulate the blood sugar levels in the body).<br><br>A review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated April 23, 2025, indicated, Resident 1 ' s Brief Interview for Mental Status (a short, structured interview designed to assess memory, attention, and orientation to determine resident's cognitive function) score was 13 (cognitively intact).<br><br>A review of Resident 1's progress note indicated:<br><br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Dated April 10, 2025, at 8:59 a.m., .patient got burned related to she spelled coffee herself on her right side .patient noted crying and stated she missed cup grip and spilled coffee herself and assessed with slight redness on right arm right breast and right ribcage area and Patient c/o (complaint of) pain 8/10 and CNA directed to change clothes to loose hospital gown and pain medication administered by LVN [licensed vocational nurse] and MD [medical doctor] Informed and Staff educated to make rounds every 15 min to assess for further changes .<br><br>- Dated, April 10, 2025, at 2:31 p.m., .Patient had blister on right side of arm and breast and c/o pain 10/10 (severe pain) and Np (Nurse Practitioner) made aware and new orders noted and carried out, give extra dose of (pain medication) and send out for Evaluations .<br><br>- Dated April 10, 2025, at 9:42 p.m. indicated, .Resident returned from (name of hospital) at approximately 8:45 .with no new orders. upon arrival patient was assessed vitals within in normal limits with a pain scale 7/10. Ordered pain medication given to patient. Patient has wounds wrapped on left arm from shoulder to elbow and also wrapped with bandage on left breast. skin assessment was done no new marks or bruises noted. care plan on going .<br><br>A review of Resident 1's hospital admission records dated April 10, 2025, indicated, .ER [emergency room] visit .F [female] .presenting with burn to right arm and breast. She reports that at her facility somebody dropped hot coffee on her arm and her breast and she has sustained a burn that occurred earlier today . Physical Examination .Skin: Burn over proximal medial [inner upper part of the right arm, near the shoulder and close to the chest] right arm and right breast with bullae [fluid filled blisters] over the right breast and abrading skin over the right elbow .Patient is presenting with burn to right arm as well as right breast .Burns appear to be superficial partial [2nd degree burn] versus deep partial thickness burn [2nd degree burn] .She will require wet to dry dressing and follow up with the burn clinic as an outpatient I have advised that the patient follow up with the local burn center either [name of the hospitals] for outpatient follow up with the burn specialist .Will prescribe pain control .<br><br>A review of Resident 1's Care Plan, dated April 11, 2025, indicated, .the resident has ACTUAL impairment to skin integrity of R ARM, R BREAST/R RIBCAGE AREA r/t BURN FROM ACCIDENTAL COFFEE SPILL . Monitor/document location, size and treatment of skin injury. Report abnormalities .failure to heal, s/sx (sign and symptom) of infection .to MD .<br><br>A review of Resident 1's Weekly wound Note, indicated:<br><br>- April 14, 2025, .RT [right] breast - 3rd degree burn [full thickness burn - destroys all layers of the skin] RT anterior forearm - 3rd degree burn RT posterior forearm - 3rd degree burn .Site of Wound and current measurement: RT Breast - 20.0x [by]10.0x0.1cm [centimeters] RT anterior forearm - 6x5x0.1 RT posterior forearm - 11x12xUTD [unable to determine] .<br><br>- April 29, 2025, .Type of Wound .Burn .Site of wound and current measurements: R breast 3x6xUTD R anterior arm - 1.5x3xUTD RT posterior arm - 1.5x3xUTD .<br><br>A review of Resident 1's Change in Condition Evaluation, dated April 14, 2025, indicated, .Signs & [and] Symptoms identified .cellulitis [infection of the skin and the underlying soft tissue] .on (R [right]) breast & R upper arm .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | There was no documented evidence Resident 1's burn injuries to the right arm and breast, sustained from the incident on April 10, 2025, was evaluated, monitored, and treated from the evening of April 10, 2025 to April 14, 2025. In addition, there was no documented evidence a follow up with the local burn center or a follow up with a burn specialist was arranged by the facility staff since Resident 1's return from the acute hospital on April 10, 2025.<br><br>A review of Resident 1's hospital records for April 17, 2025, indicated, .presented to the ER for altered mental status of 1 day .patient states she feels tired today .she has right upper extremity right breast burn and drainage secondary to hot coffee accidentally poured on her. Skin Right upper extremity and right breast wounds with drainage, abscess formation and associated erythema .open wound to right extremity altered mental status likely secondary to current wound infection .open wound of right upper extremity and right breast wound secondary to burn with hot coffee .looks infected with drainage and abscess formation .wound care referral .She was seen here 6 days ago for burn on her right extremity and her right breast. Has been undergoing dressing changes at her facility. Will treat empirically for possible infectious etiology. Clinical exam is consistent with healing burns of her arm and her breast without superimposed infection . Wounds dressed with wet to dry .<br><br>A review of Resident 1's physician ' s order dated May 5, 2025, at 10:02 a.m. indicated, .May Have Follow up Appointment with (name and address of burn center). This physician order was obtained by the facility staff from the physician 25 days after the onset of Resident 1's burn on April 10, 2025.<br><br>On May 7, 2025, at 12:15 p.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 stated, according to facility policy, during admissions, the registered nurse was responsible for following up on discharge orders. RN 1 stated, if there was no discharge paperwork received, the licensed nurse was expected to obtain hospital recommendations and communicate the information during each shift change. RN 1 stated, she was the RN supervisor on April 11, 2025, and she was not given any report or endorsed any new orders for Resident 1 from the night shift. RN 1 stated, the hospital recommendation should have been followed up.<br><br>On May 7, 2025, at 2:39 p.m., an interview with the treatment Nurse (TN) was conducted. The TN stated, on April 14, 2025, (four days after the onset of the burn) she conducted an initial assessment of two burn sites on Resident 1's right arm and right breast, and treatment orders were initiated. The TN stated, she was not made aware Resident 1 sustained burns on April 10, 2025. The TN stated, per protocol, when there was a change in condition involving the skin, the treatment team should be notified, the physician informed, and a timely assessment and treatment provided to address the resident's immediate needs. The TN stated, she should have been informed on April 10, 2025, the day of the incident that Resident 1 sustained burn injuries. The TN further stated that delayed treatment of burns could result in worsening of the wound and further injury.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On May 7, 2025, at 3:45 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated it was the facility policy for nursing staff to receive a detailed report from the hospital upon a resident's readmission. The DON stated, if there were no documents provided at the time of a resident's admission, the licensed nurses were expected to make continued efforts to obtain the hospital's discharge instructions and recommendations, to ensure appropriate care was rendered. The DON stated, Resident 1's readmission hospital record from April 10, 2025, were not obtained by the facility staff until April 16, 2025. The DON stated, these records should have been obtained the following day. The DON stated, the licensed nurses did not follow up appropriately. The DON further stated any changes in condition involving the skin should be reported to the nursing supervisor, DON, physician, family, and treatment team so that proper assessment and treatment can be provided. The DON stated, Resident 1's burn injuries on April 10 and 11, 2025, should have been evaluated according to facility policy to prevent further worsening. The DON stated, the hospital's recommendations from April 10, 2025, for a two-day follow-up with a burn center was not identified or acted upon by the facility staff until May 5, 2025. The DON stated this recommendation should have been communicated to the nursing staff earlier, so Resident 1 could have been evaluated by a burn specialist in a timely manner.<br><br>On May 8, 2025, at 10:40 a.m., a concurrent observation and interview were conducted with Resident 1. Resident 1 was observed to be alert and seated in her wheelchair, with clean white bandages on her right upper arm and right chest area. Resident 1 stated, she recalled the incident on April 10, 2025. Resident 1 stated she had asked for tea, and she was asleep when the hot beverage was served. Resident 1 stated she was being awakened by the spill, screamed in pain. Resident 1 stated the hot beverage was spilled on her but did not confirm how it happened. Resident 1 stated, she could not recall when treatment for her burns was started.<br><br>A review of the facility policy and procedure titled, Acute Condition Changes, undated, indicated, .the nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications . the physician will help identify and authorize appropriate treatments .the staff will monitor and document the resident ' s progress and responses to treatment .<br><br>A review of the facility policy and procedure titled, Appointments, undated, indicated, .facility provides residents in accessing specialty healthcare services to enhance their health and wellbeing .appointments ordering .appointments are documented in the electronic record .nursing staff informs the unit clerk or designee about the appointment order .the unit clerk schedules appointments based on medical necessity .<br><br>2. On May 7, 2025, Resident 4 ' s records were reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), diabetes (inability to regulate blood glucose in the body), long term use of aspirin (use of a medication which makes the blood thin).<br><br>A review of Resident 4's Minimum Data Set (an assessment tool), dated April 23, 2025, indicated, Resident 1 ' s Brief Interview for Mental Status (a short, structured tool used to assess cognitive functions) score was 10 (moderate cognitive impairment).<br><br>A review of Resident 4's physician ' s order dated June 28, 2023, indicated, .Monitor for s/s of bleeding Qshift (every shift) MB (manifested by), hematoma, Gi bleeding, occult blood discoloration, Blood in emesis .if present notify MD .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the Care Plan initiated June 29, 2023, indicated, .Risk for bleeding /bruising due to used of anticoagulant for prophylaxis .Check body & report to MD (physician) any of the following S/S (signs and symptoms) of bleeding .Hematoma . Discoloration .Handle resident with gentle care during ADL care. Keep environment hazard-free and safe<br><br>A review of Resident 4's skin task log dated April 27, 2025, at 12:50 p.m., indicated .discoloration location. Other is checked .<br><br>A review of Resident 4's Weekly Skin Nursing documentation dated April 27, 2025, at 11:50 a.m. indicated, . Section L labeled Skin .Does the resident have any new skin concerns . (NO) is checked .Does the resident currently have any existing skin conditions (intact).<br><br>There was no documented evidence of further assessment conducted on Resident 4's identified skin discoloration identified by the CNA on April 27, 2025, at 12:50 p.m.<br><br>A review of the Care Plan initiated June 29, 2023, indicated, .Risk for bleeding /bruising due to used of anticoagulant for prophylaxis .Check body & report to MD (physician) any of the following S/S (signs and symptoms) of bleeding .Hematoma . Discoloration .Handle resident with gentle care during ADL care. Keep environment hazard-free and safe<br><br>On May 6, 2025, at 11:52 a.m., an interview was conducted with Resident 4, with the Licensed Vocational Nurse (LVN 3) acting as interpreter. Resident 4 was alert, calm and lying in bed sitting upright. Resident 4 presented her left hand and was observed to have a large dark purple and blue circular bruise covering the top part of her right hand and a large circular purple and blue bruise with a small square dressing over the top of her left hand.<br><br>On May 6, 2025, at 2:30 p.m., an interview with Certified Nursing Assistant (CNA) 3. CNA 3 stated on the morning of April 27, 2025, she identified a large bruise to the left hand of Resident 4. CNA 3 stated, when a skin change was noted, the staff should report it to the charge nurse, and the nurse would evaluate the resident and reported to the MD. CNA 3 stated, she reported Resident 4's skin discoloration to the charge nurse on April 27 and to the RN Supervisor and the DON on April 28, 2025.<br><br>On May 8, 2025, at 2:00 p.m., an interview was conducted with LVN 4. LVN 4 stated, all new skin changes should be assessed, and a change of condition should be made so that the proper treatment could be rendered and communicated to the physician. LVN 4 stated, she did not notice the bruise on Resident 4's right hand. LVN 4 stated, a change of condition assessment should have been completed.<br><br>On May 8, 2025, at 2:08 p.m. an interview was conducted with LVN 3. LVN 3 stated, she was made aware of the bruise to the left hand of Resident 4 on April 28, 2025, and a change of condition was made. LVN 3 stated Resident 4 was taking a medication that placed her at risk for bleeding. LVN 3 stated a skin assessment should be conducted each shift and evaluated weekly. LVN 3 stated any skin changes should be documented. LVN 3 stated, she did not report and identify any skin changes for Resident 4 on April 27, 2025.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On May 8, 2025, at 3:13 p.m. an interview was conducted with the DON. The DON stated the facility's policy for skin change, CNA's are to report skin changes to the charge nurse, and the charge nurse should report to the RN or DON. The DON stated the bruise found on Resident 4 was not reported and it should have been. The DON further stated any discolorations on the skin should be documented in the assessment record with a description of the bruise and the location which was not done for Resident 4 according to the facility policy and procedures. The DON stated the risks for not monitoring bleeding could lead to a worsening of the site and should have been monitored. The DON stated the facility policy is that nurses should conduct detailed assessments which includes risks, such as bleeding and skin changes.<br><br>A review of the facility policy and procedure titled, Anticoagulation -Clinical Protocol, undated, indicated, . staff will identify individuals who are currently anticoagulated .the staff will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems .if individuals show signs of excessive bruising .or other evidence of bleeding, the nurse will discuss the situation with the physician .<br><br>A review of the facility policy and procedure titled, Acute Condition Changes, undated, indicated, .the nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications . the physician will help identify and authorize appropriate treatments .the staff will monitor and document the resident ' s progress and responses to treatment .<br><br>3. On May 7, 2025, Resident 6 's medical record was reviewed. Resident 6 was admitted on [DATE], with a diagnosis which included, Diabetes (inability to regular blood glucose in the body, and Peripheral Vascular Disease (PVD - poor blood circulation to the upper and lower extremities). Resident 6 was discharged to acute care hospital on April 24, 2025.<br><br>A review of Resident 6's History and Physical, dated February 24, 2025, indicated, .does have decision making capacity.<br><br>A review of Resident 6's admission document dated February 11, 2025, .Skin condition Does resident have any skin issues YES .Description .Left 5th toe: DM ulcer .right 5th toe .DM ulcer .resident a/o x 4 able to make needs known, noted above txt (treatment) initiated, and completed- resident verbalized continue care within house wound (name of physician) continue with plan of care Pedal Pulses .palpable. Both right and left .<br><br>A review of the physician 's orders indicated the following:<br><br>.Right 5thtoe clean w/NS paint with betadine daily leave open to air every shift for DM ulcer and as needed for replacement start date 2/3/2025 end dated 4/15/2025 . and<br><br>.Left 5thtoe: clean w/NS pained with betadine daily leave open to air every shift for DM ulcer and as needed for replacement start date 2/3/2025 end date 4/15/2025 .<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the Care Plan dated February 12, 2025, indicated, .At Risk and or potential for further skin breakdown. Fragile skin, Poor mobility, intermittent claudication, Dx (diagnosis of DM (Diabetes Mellitus) , presence of DM ulcer . Will minimize skin impairment x90 days .C.N.A. to report any skin abnormalities to the LN/RN Charge Nurse when showering/bathing resident nursing to complete weekly skin assessment .<br><br>A review of Resident 6's document titled, Weekly Nursing (weekly skin) indicated:<br><br>- Dated March 23, 2025, .does the resident have any new skin conditions .NO .Does the resident currently have any existing skin conditions .intact is checked NO notes (there is no documented evidence or a description of the skin conditions).<br><br>- Dated April 13, 2025, .Does the resident have any new skin concerns .NO .Does the resident currently have any existing skin conditions Intact .NO notes. (there is no documented evidence or a description of the skin conditions).<br><br>A review of the Weekly wound note, indicated:<br><br>- Dated March 10, 2025, .re-admission 2/11/25 .Type of Wound: Pressure, Vascular, Diabetic, Surgical, Other: 1-2: diabetic ulcer .Site of Wound and current measurements: 1: left 5th toe: (3x2xUTD -[unable to determine]) .2: right 5th toe: (1.5x1xuUTD) .Wound bed description:: 1: 100% necrotic tissue (dead tissue) 2: 100% necrotic tissue .<br><br>- Dated March 24, 2025, .Type of Wound: Pressure, Vascular, Diabetic, Surgical, Other: 1-2 diabetic ulcerSite of Wound and current measurements 1: left 5th toe: 4.0x4.0xUTD2: right 5th toe: 3.0x4.0xUTD . Wound bed description . 1-2: 100% epithelial (thin layer of tissue that covers the outer surface of the body) .<br><br>There was no documented evidence of a change of condition was identified and referred to the physician when the left 5th toe and right 5th toe wound size increased from March 10, 2025 to March 24, 2025.<br><br>On May 13, 2025, at 1:53 p.m. an interview and record review were conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 6 received wound treatments since admitted on [DATE], until he was discharged on April 24, 2025. LVN 1 stated during the weekly wound rounds treatments, residents' wounds will be documented, measured, and assessed. LVN 1 stated Resident 6's increased wound size on his left and right 5th toe were not reported as a change in condition during the treatments conducted between March 10, 2025, to March 24, 2025. LVN 1 stated this should have been identified as a change in condition and it should have been reported to the physician. LVN 1 stated there was a potential for a delay in treatment and result to the worsening of a wound if the change of condition was not communicated to the physician in a timely manner.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On May 13, 2025, at 2:08 p.m. an interview and record review were conducted with the Director of Nursing (DON). The DON stated during the weekly wound rounds, the licensed nurses should communicate the latest skin condition assessment. The DON stated identified changes in condition should be documented and reported to the RN supervisor, DON, and the physician. The DON stated between March 10, 2025, and March 24, 2025, there was no change of condition identified and documented for Resident 6 's increased wound size on his left and right 5th toe. The DON stated this should have been done. The DON stated he was not made aware of the worsening wound for Resident 6 until April 11, 2025. The DON further stated there could be a potential for a wound to worsen if a change of condition was not communicated to the staff and physician in a timely manner.<br><br>A review of the facility policy and procedure titled, Acute Condition Changes, undated, indicated, .the nursing staff will review the details of any recent hospitalization and will identify complications and problems that occurred during the hospital stay that may indicate instability or the risk of having additional complications . the physician will help identify and authorize appropriate treatments .the staff will monitor and document the resident ' s progress and responses to treatment . |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an environment free of accident hazards was provided for one of three sampled residents (Resident 1) when Resident 1 was served a hot beverage by a Certified Nursing Assistant (CNA 1) without checking the safe serving temperature on April 10. 2025.<br><br>This failure resulted in the hot beverage spilling on Resident 1 causing burn injuries, second degree burn [partial thickness burn - affects both the outer layer and part of the underlying layer of the skin] to third degree burn [most severe type of burn that damages all layers of the skin] on her right breast and shoulder that required medical intervention.<br><br>Findings:<br><br>On May 7, 2025, Resident 1's admission record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnosis of metabolic encephalopathy (a brain disorder that results from a disturbance in metabolism, causing brain dysfunction) and multiple strokes with residual hemiplegia (persistent weakness or paralysis on one side of the body), right side.<br><br>A review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated April 23, 2025, indicated, Resident 1 ' s Brief Interview for Mental Status (BIMS - short, structured interview to assess memory, attention, and orientation) score was 13 (cognitively intact). The MDS indicated Resident 1 required supervision or touching assistance when eating and needed some help with need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness.<br><br>A review of Resident 1's care plan dated April 22, 2025, indicated, .The resident has an ADL (activities of daily living) self-care performance deficit r/t [related to] Hx [history] of cerebral infarction [a type of stroke] with hemiplegia/hemiparesis [weakness or partial loss of strength on one side of the body] .Interventions . Eating: The resident requires set up assistance with eating .<br><br>A review of Resident 1's progress note indicated:<br><br>- On April 10, 2025 at 8:59 a.m., the Licensed Nurse (LN) documented, patient got burned related to she spelled (sic.) coffee herself on her right side .patient noted crying and stated she missed cup grip and spilled coffee herself and assessed with slight redness on right arm right breast and right ribcage area and Patient c/o (complaint of) pain 8/10 [pain rating scale of 8 - severe pain] and CNA directed to change clothes to loose hospital gown and pain medication administered by LVN [licensed vocational nurse] and MD [medical doctor] Informed and Staff educated to make rounds every 15 min to assess for further changes .<br><br>- On April 10, 2025, at 2:31 p.m., the LN documented., .Patient had blister [fluid-filled sac beneath or within the skin caused by burn] on right side of arm and breast and c/o pain 10/10 and Np [Nurse Practitioner] made aware and new orders noted and carried out, give extra dose of [pain medication] and send out for Evaluations .<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555566 | A. Building<br>B. Wing | 05/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Corona Post Acute Center | 2600 South Main Street<br>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.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | - On April 10, 2025, at 9:42 p.m., the LN documented, .Resident returned from [name of hospital] at approximately 8:45 .with no new orders. upon arrival patient was assessed vitals within in normal limits with a pain scale 7/10 Ordered pain medication given to patient [Resident 1]. Patient has wounds wrapped on left arm from shoulder to elbow and also wrapped with bandage on left breast. skin assessment was done no new marks or bruises noted. care plan on going .<br><br>A review of Resident 1's hospital admission records dated April 10, 2025, indicated, .ER [emergency room] visit .F [female] .presenting with burn to right arm and breast. She reports that at her facility somebody dropped hot coffee on her arm and her breast and she has sustained a burn that occurred earlier today . Physical Examination .Skin: Burn over proximal medial [inner upper part of the right arm, near the shoulder and close to the chest] right arm and right breast with bullae [fluid filled blisters] over the right breast and abrading skin over the right elbow .Patient is presenting with burn to right arm as well as right breast .Burns appear to be superficial partial [2nd degree burn] versus deep partial thickness burn [2nd degree burn] .She will require wet to dry dressing and follow up with the burn clinic as an outpatient I have advised that the patient follow up with the local burn center either [name of the hospitals] for outpatient follow up with the burn specialist .Will prescribe pain control .<br><br>A review of Resident 1's Weekly wound Note, indicated:<br><br>- April 14, 2025, .RT [right] breast - 3rd degree burn [full thickness burn - destroys all layers of the skin] RT anterior forearm - 3rd degree burn RT posterior forearm - 3rd degree burn .Site of Wound and current measurement: RT Breast - 20.0x [by]10.0x0.1cm [centimeters] RT anterior forearm - 6x5x0.1 RT posterior forearm - 11x12xUTD [unable to determine] .<br><br>- April 29, 2025, .Type of Wound .Burn .Site of wound and current measurements: R breast 3x6xUTD R anterior arm - 1.5x3xUTD RT posterior arm - 1.5x3xUTD .<br><br>A review of Resident 1's Change in Condition Evaluation, dated April 14, 2025, indicated, .Signs & [and] Symptoms identified .cellulitis [infection of the skin and the underlying soft tissue] .on (R [right]) breast & R upper arm .<br><br>On May 7, 2025, 1:37 p.m. an interview was conducted with CNA 1. CNA 1 stated, she was assigned to Resident 1 on April 10, 2025, morning shift. CNA 1 stated, Resident 1 asked for a cup of tea while eating breakfast. CNA 1 stated, she placed a tea bag in a cup and placed the cup in a microwave to heat the water up to a warmer temperature. CNA 1 stated, she did not check the temperature of the hot tea prior to serving it to Resident 1. CNA 1 stated she was not aware the temperature of the hot beverage needed to be checked prior to serving it to the resident. CNA 1 stated, she should have checked the temperature of the hot tea before serving it to Resident 1 as there was a risk of burn injury with serving hot beverages.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On May 7, 2025, at 2:11 p.m., an interview was conducted with CNA 2. CNA 2 stated, she assisted CNA 1 on the morning of April 10, 2025, when Resident 1 was heard to be screaming. CNA 2 stated, she noticed a cup of hot water and not coffee, had spilled to the right breast and right shoulder of Resident 1 and that she was in pain. CNA 2 stated, she and CNA 1 immediately changed the soiled clothes and Resident 1 stated I am sorry I spilled on me. CNA 2 stated, Resident 1 did not appear to be confused at that time. CNA 2 stated, she was instructed upon hire that hot food and beverages should not be served by reheating unless the temperature was checked to be within a specified range. CNA 2 stated, she would not serve hot food or beverages to residents without having the kitchen to verify it first as there was a risk for injury and burn.<br><br>On May 7, 2025, at 3:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated it was the policy of the facility that nursing staff including CNA's and nurses should check for safe serving temperature before serving it to the resident. The DON stated this was not done by CNA 1 when she served the hot tea to Resident 1 on April 10, 2025, and the hot liquid was accidentally spilled on Resident 1 which resulted to Resident 1 sustaining second degree burns on her right breast and right shoulder.<br><br>On May 8, 2025, at 10:40 a.m. a concurrent observation and interview were conducted with Resident 1 in the resident's room. Resident 1 was observed to be alert and up in her wheelchair. Resident 1 had a clean white bandage on her right upper arm and right chest area. Resident 1 stated, she recalled the incident on April 10, 2025. Resident 1 stated, she asked a CNA for tea. Resident 1 stated, she was not fully awake when CNA 1 served tea and was awoken by the hot beverage spilled on her Resident 1 stated she screamed in pain and the staff responded. Resident 1 stated, she was experiencing pain and she was provided pain medication. Resident 1 stated she did not recall being warned by CNA 1 before being served the hot beverage. Resident 1 stated the hot beverage was brought to her and placed on the bedside table within her reach, but she could not recall if it was spilled on her by staff or by accident after she awoke from a brief sleep.<br><br>A review of the facility policy and procedure titled, Food Service Temperature Control, dated, 2024, indicated, .Beverages .brewed coffee and hot water .will be portioned in small batches to retain the temperature .served at or below 155 degrees F (Fahrenheit) to prevent burns .<br><br>A review of the facility policy and procedure titled, Hot Beverage Preparation and Service, undated, indicated, .Hot Beverages will be prepared following food safety standards and served at a safe temperature to prevent burns or injury .Measure beverage temperatures prior to service using a calibrated food thermometer to ensure compliance with the safe serving temperature . |