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	04/10/2026

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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure for five of 32 residents reviewed for quality of care (Residents 4, 19, 101, 178, and 180) when:1.For Resident 4, the intravenous (IV- specific location on the body where a small, flexible tube (catheter) is inserted into a vein to deliver medication) medications Meropenem (type of antibiotic) and Linezolid (type of antibiotic) were not documented as administered according to the physician orders.This failure had the potential to result in ineffective treatment of infection, worsening of the resident's condition, and development of antibiotic resistance; and2.For Resident 19, the IV medication Ceftriaxone (type of antibiotic) was not documented as administered according to the physician orders.This failure had the potential to result in ineffective treatment of infection, progression of urinary tract infection (when germs get into the urine system and cause infection), and potential complications such as sepsis (life-threatening condition caused by the body's extreme response to an infection); and3.For Resident 178, the facility did not schedule the ENT (Ear, Nose, and Throat) consultation according to the physician orders.This failure resulted in a delay in medical evaluation and had the potential to cause worsening of the resident's condition and prolonged pain; and 4.For Resident 101, the facility did not identify a significant change in the meal intake of less than 50% for multiple days between March 2026 to April 2026.This failure increased the risk of the resident not receiving the services necessary for her nutrition and health status; and 5. For Resident 180, a timely implementation of physician-ordered speech therapy services for one of three residents (Resident 180).This failure had the potential to place the resident at risk for aspiration, choking, and receiving an inappropriate diet texture.Findings: 1.A review of Resident 4's physician's order dated February 23, 2026, indicated the following: .Meropenem Intravenous Solution Reconstituted 1GM (gram- unit of measurement) Use 1 gram intravenously every 12 hours for s/p (status/post) coccyx (tailbone) wound debridement until March 10, 2026. and; .Linezolid Intravenous Solution 600 MG/300 ML (milligram/milliliter - unit of measurement) (Linezolid) Use 600 mg intravenously every 12 hours for s/p coccyx wound debridement until March 11, 2026. There was no documented evidence in Resident 4's Medication Administration Record (MAR) that Linezolid doses were administered. On April 9, 2026, at 10:10 a.m., a concurrent interview and record review of Resident 4's MAR (medication administration record) was conducted with the Infection Preventionist (IP), the IP stated there was no documentation in the MAR that Linezolid was administered on February 27, 28, March 4, 5, and 10, 2026, (6 a.m. doses), and no documentation that Meropenem was administered on March 1, 2026 (9 p.m. dose). The IP stated the if a medication was not documented as administered, it was (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 - Some	considered not given. 2.On April 6, 2026, at 3:51 p.m., Resident 19 was observed alert, oriented, and watching television. In a concurrent interview with Resident 19, she stated the IV was placed when she was in the hospital for a UTI (urinary tract infection). Resident 19's record was reviewed. Resident 19 was admitted to the facility on [DATE], with diagnoses which included UTI. The history and physical, dated April 1, 2026, indicated Resident 19 had the capacity to make decisions. The physician order dated March 31, 2026, indicated ceftriaxone sodium 1 gm intravenously one time a day for UTI for 5 days. A review of the electronic Medication Administration Record (eMAR) for the month of April 2026, indicated the 6 a.m. dose of Ceftriaxone was not administered on April 2, 2026. There was no documented evidence the medication was administered as ordered. On April 8, 2026, at 3:35 p.m., a concurrent interview and record review was conducted with the Registered Nurse (RN 2). RN 2 stated the EMAR (electronic medication administration record) indicated the 6 am dose of the medication Ceftriaxone 1 gm intravenously was not administered on April 2, 2026. RN 2 stated the medication Ceftriaxone should have been administered as ordered and the physician should have been notified of the missed dose. On April 10, 2026, at 8:31 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated licensed nurses were expected to administer medications as ordered, document administration in the eMAR, and notify the physician when medications were not administered. The DON stated licensed nurses should have administered the 6 am dose of the IV medication Ceftriaxone according to the physician order and documented in Resident 19's EMAR. The DON stated the facility process for following physician's orders for administration of medication was not followed and should have been followed. A review of the facility policy and procedure titled Administering Medications, revised April 2019, indicated .The individual administering the medication initials the residents' MAR on the appropriate line after giving each medication and before administering the next ones.as required or indicated for a medication, the individual administering the medication record s (sic) in the resident's medical record: The date and time the medication was administered.The signature and title of the person administering the drug. A review of the facility policy and procedure titled Physician Orders, dated January 23, 2026, indicated .Ensure orders are followed correctly .Responsibilities Nursing .Receive, verify, and implement orders .ensure documentation accuracy . 3. On April 7, 2026, at 10:44 a.m., Resident 178 was observed alert, oriented, lying upright in bed. Resident 178 stated during her care conference on April 2, 2026, she informed the care team of right ear pain. Resident 178 stated the team informed her an ENT consultation would be scheduled. Resident 178 stated five days had passed and she had not been informed of a scheduled appointment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 178's records were reviewed. Resident 178 was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of pancreas (cancer tumor of the pancreas), obstruction of duodenum (intestinal blockage), major depressive disorder (intense feeling of sadness), and anxiety disorder (excessive fear of real or perceived thought). The history and physical dated March 29, 2026, indicated Resident 178 had the capacity to understand and make medical decisions. The physician order dated April 2, 2026, indicated .Refer to ENT Consultation per patient request. The IDT Note dated April 2, 2026, indicated .ENT referral right ear issues . There was no documented evidence that an ENT consultation appointment was scheduled from April 3 through April 8, 2026. On April 9, 2026, at 1:01 p.m., a follow up interview was conducted with Resident 178. Resident 178 stated the facility had still not provided an update regarding the ENT consultation appointment and she continued to experience increased right ear pain. On April 9, 2026, at 1:40 p.m., an interview was conducted with the Social Service Director (SSD). The SSD stated she was responsible for scheduling the resident's ENT consultation. The SSD stated ENT physician scheduled visits was every six months and Resident 178 was scheduled to be seen on the next visit. The SSD stated she should have asked Resident 178 if she would like to be seen by an outside physician since the physician already visited within the six-month window. The SSD stated the possible outcome of not scheduling resident for her acute ear pain as soon as applicable had the potential to result in a delay in medical care and a worsening of pain. On April 10, 2026, at 12:49 p.m., a concurrent interview and record review was conducted with the Administrator (ADM). The ADM stated there was no documentation that the ENT consultation appointment was scheduled between April 3 and April 8, 2026. The ADM stated the consultation should have been arranged in a timely manner to address the resident's condition. The ADM stated the SSD should have offered Resident 178 to arrange for a visit from the outside physician and arranged the ENT consultation appointment to address her pain prior to April 9, 2026. A review of the facility policy and procedure titled Resident Appointments (Scheduling and Management), dated January 23, 2026, indicated, .The facility will ensure that all resident appointments are scheduled, coordinated, and completed in a timely manner to support continuity of care, resident safety, and regulatory compliance To: Ensure residents receive necessary medical services.prevent missed or delayed appointments.Appointments may be scheduled for.Specialty care.staff will schedule appointments promptly per physician order.Document appointment details (date, time, provider, location).Notify resident and/or responsible party of: appointment date and time.purpose of visit.document notification in medical record. 4. A review of Resident 101's record indicated Resident 101 was admitted to the facility on [DATE], with diagnoses including morbid obesity (severe fat accumulation), chronic kidney disease (reduced kidney function), and anemia (a condition of the blood which reduces the blood's ability to transport oxygen). The Minimum Data Set (MDS - an assessment tool), dated March 15, 2026, indicated a BIMS (Brief (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview of Mental Status) score of 15 (cognitively intact). A review of the Food and nutritional assessment dated March 18, 2026, indicated, .resident consumes mostly 25% for all meals (breakfast, lunch, and dinner). Nutrition intervention/recommendations: 4oz (ounce – a unit of measurement) Health Shake TID (three times a day) w (with) /meals x (for) 14 days for inadequate PO intake.Current weight over IBWR (ideal body weight ration).Continue to monitor PO (by mouth) intake, skin integrity, weight trends, labs.Reassess as needed. A review of the nutrition report from March 18 to April 8, 2026, indicated an average meal percentage of 41%. A review of the meal intake percentage tasks documented by the facility staff from March 14 through April 8, 2026, indicated ongoing poor intake, including: -Meal intake of 25-50%: 18 instances. -Meal intake of 0-25%: 4 instances. -Meal percentage with refusal: 18 instances. Despite ongoing poor intake following initiation of nutritional interventions, there was no evidence the facility evaluated or addressed the resident's continued nutritional decline. There was no documented change of condition, no reassessment by the Registered Dietitian. A review of the progress note dated March 19, 2026, at 9:12 a.m. indicated, .MD (physician) and RD (registered dietitian) .health shake with meals for inadequate po intake for 14 days.start date.March 19, 2026.End date April 2, 2026. Further review of Resident 101's record, indicated no evidence of follow-up or reassessment after the completion of this intervention despite continued poor intake. On April 8, 2026, at 3:55 p.m., an interview was conducted with Registered Nurse (RN 1). RN 1 stated that changes in intakes should be reported to the physician and reflected in the care plan and stated this was not done. On April 9, 2026, at 1:28 p.m., an interview and record review were conducted with the Registered Dietitian (RD). The RD stated he was not notified of Resident 101's continued poor intake after his initial recommendation and did not reassess the resident. On April 9, 2026, at 2:03 p.m., a concurrent interview and record review were conducted with LVN 1. LVN 1 stated if an intake falls below 75% on 3 occasions, initiate a Change of Condition (COC), update the care plan, notify MD (physician) and monitor for 72 hours. LVN 1 stated there was no documentation of ongoing nutritional monitoring for Resident 101, no progress notes reflecting deteriorating intake, and no COC or care plan updates. On April 9, 2026, at 2:48 p.m. a concurrent interview and record review were conducted with the Director of Nursing (DON). The DON stated that intake consistently below 50% on three occasions should trigger a COC and physician notification. The DON stated the facility did not recognize and address the resident's ongoing poor intake. (continued on next page)

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