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	06/23/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) drainage bag (connected to the urinary catheter to collect urine) were covered with dignity bag (a discreet cover or holder designed to conceal a Foley catheter drainage bag [which holds urine] and its connecting tube out of public view) for two of four residents reviewed with urinary catheters (Resident 2 and Resident 3). This failure had the potential to compromise the residents' dignity and privacy.Findings: On May 15, 2026, at 10:30 a.m., an unannounced visit to the facility on a complaint investigation was initiated. 1. On May 15, 2026, at 11:41 a.m., observed Resident 2's urinary catheter bag hanging on the bed frame on the left side of the bed without a dignity bag covering it. The room door was open, and the drainage bag was visible from the doorway and could be readily viewed by staff and visitors entering or passing by the room. On May 15, 2026, at 11:54 a.m., a concurrent observation and interview was conducted with the Infection Preventionist, (IP). The IP confirmed that Resident 2's urinary catheter drainage bag was not covered with a dignity bag. The IP stated residents with urinary catheters should have the drainage bag covered with a dignity bag to promote privacy and dignity. A review of Resident 2's medical records indicated the resident was admitted on [DATE], with diagnoses of urinary tract infection, (infection in the bladder) and obstructive uropathy (any structural or functional blockage that slows or stops the flow of urine through the urinary tract). A review of Resident 2's History and Physical dated April 24, 2026, indicated resident had fluctuating capacity to make decisions. A review of Resident 2's Order Summary Report dated April 26, 2026, indicated May have. foley catheter r/t [related to] obstructive uropathy . 2. On May 15, 2026, at 12:06 p.m., observed Resident 3's urinary catheter drainage bag hanging on the left side of the bed frame without a dignity bag covering it. The room door was open, and the drainage bag was visible from the doorway and could be readily viewed by staff and visitors entering or passing by the room. On May 15, 2026, at 12:13 p.m., an interview was conducted with the Licensed Vocational Nurse, (LVN). The LVN stated Resident 3's urinary catheter drainage bag should have been covered with a dignity bag to maintain resident privacy. A review of Resident 3's medical records indicated the resident was admitted on [DATE], with diagnoses of metabolic encephalopathy, (a problem in the brain caused by a chemical imbalance in the blood), urinary tract infection, and obstructive uropathy (any structural or functional blockage that slows or stops the flow of urine through the urinary tract) A review of Resident 3's History and Physical dated March 12, 2026, indicated resident had fluctuating capacity to understand and make decisions. A review of Resident 3's Order Summary Report dated May 8, 2026, indicated .foley catheter.

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	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 call lights were within reach for two out of four residents reviewed (Resident 2 and Resident 3). This failure had the potential to delay residents' ability to obtain assistance for care needs, increase the risk of falls, and result in unmet needs or injury.Findings: On May 15, 2026, at 10:30 a.m., an unannounced visit to the facility on a complaint investigation was initiated. 1. On May 15, 2026, at 11:41 a.m., observed Resident 2 in bed. The call light was hanging on the wall on the left side of the resident's bed, out of his reach. On May 15, 2026, at 11:41 a.m., an interview was conducted with Resident 2. Resident 2 could answer yes and no questions by shaking his head up and down for yes, and back and forth for no. Resident 2 was asked where his call light was, Resident 2 shrugged his shoulders. When Resident 2 was asked how he calls for assistance, Resident 2 placed his hands up around his mouth and whispered he yells. Resident 2 shook his head up and down when asked whether this was frustrating and shrugged his shoulder when asked whether he felt safe. On May 15, 2026, at 11:54 a.m., a concurrent observation and interview was conducted with the Infection Preventionist, (IP). At Resident 2's bedside, the IP was asked where Resident 2's call light was. She was unable to locate the call light within the resident's reach and confirmed that the call light should have been within reach at all times for Resident 2. A review of Resident 2's medical records indicated resident was admitted on [DATE], with diagnoses which included hemiplegia, (paralysis of one side of the body), and hemiparesis, (weakness of one side of the body), following cerebral infarction, (also known as a stroke, refers to damage to tissues in the brain due to a loss of oxygen to the area). A review of Resident 2's History and Physical dated April 2, 2025, indicated resident had fluctuating capacity to make decisions. A review of Resident 2's Care Plan Report initiated on April 25, 2026, indicated Focus High risk for falls.Interventions: Keep call light within reach. 2.On May 15, 2026, at 12:06 p.m., heard Resident 3 yelling for help from room (room number). Observed Resident 3 in bed, his call light was hanging at the head of his bed outside of his reach. On May 15, 2026, at 12:06 p.m., an interview was conducted with Resident 3. Resident 3 stated that he needed help and wanted to be pulled up in his bed. A review of Resident 3's medical records indicated resident was admitted on [DATE], with diagnoses of metabolic encephalopathy, (a problem in the brain caused by a chemical imbalance in the blood), urinary tract infection, acute respiratory failure, (a serious condition that develops quickly without warning when the lungs can't get enough oxygen into the blood), COPD, and type 2 diabetes mellitus. A review of Resident 3's History and Physical dated March 12, 2026, indicated resident had fluctuating capacity to understand and make decisions. A review of Resident 3's Care Plan Report initiated January 22, 2026, indicated Focus: Risk for falls. Interventions: ensure call light, personal items and water picture side table are within reach. On May 15, 2026, at 12:13 p.m., an interview was conducted with the Licensed Vocational Nurse, (LVN). The LVN observed Resident 3 and stated that the call light was not within reach and confirmed that the call light should have been within reach for Resident 3. On May 15, 2026, at 12:37 p.m., an interview was conducted with the Certified Nursing Assistant, (CNA). The CNA stated that Resident 3 knew how to use the call light, and it was important for the call light to be within reach so the resident could call for help when needed. A review of the facility's policy and procedure titled Answering the Call Light revised May 2025, indicated .1. Resident Access Each resident shall have access to a functioning call light device at all times. Staff shall ensure the call light is within the resident's reach during routine care, after transfers, and before leaving the room.

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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** Based on observation, interview, and record review, the facility failed to ensure infection prevention practices were maintained when the urinary catheter drainage bag, (connected to the urinary catheter - a hollow tube inserted into the bladder to drain or collect urine), was observed touching the floor for one of four residents reviewed, (Resident 3). This failure had the potential to contaminate the urinary drainage system and increase the risk of contamination of the urinary drainage system, and the development of a catheter associated urinary tract infection (CAUTI - happens when germs (usually bacteria) enter the urinary tract through a medical catheter that is placed into the bladder). Findings: On May 15, 2026, at 10:30 a.m., an unannounced visit to the facility on a complaint investigation was initiated. On May 15, 2026, at 12:06 p.m., observed Resident 3 in bed. His urinary catheter bag was hooked onto the left side of the bed frame and was touching the floor. On May 15, 2026, at 12:13 p.m., an interview was conducted with the Licensed Vocational Nurse, (LVN). The LVN stated that Resident 3's urinary catheter drainage bag should not be in contact with the floor because doing so could increase the risk of contamination and infection. On May 15, 2026, at 2:56 p.m., an interview was conducted with the Infection Preventionist, (IP). The IP stated that urinary catheter drainage bags should be stored in a bath basin and should not touch the floor. The IP confirmed that contact with the floor could increase the risk of contamination of the urinary drainage system and the development of a CAUTI. A review of Resident 3's medical records indicated the resident was admitted on [DATE], with diagnoses of metabolic encephalopathy, (a problem in the brain caused by a chemical imbalance in the blood), urinary tract infection, acute respiratory failure, (a condition in which the lungs cannot provide adequate oxygen to the blood), COPD, and type 2 diabetes mellitus. A review of Resident 3's History and Physical dated March 12, 2026, indicated the resident had fluctuating capacity to understand and make decisions. A review of Resident 3's Order Summary Report dated May 8, 2026, indicated .foley catheter. A review of the facility's policy and procedure titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing revised April 2025, indicated .6. Maintain unobstructed urine flow . c. Keep drainage bag below the level of the bladder at all times. Do not place the drainage bag on the floor .