California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA240000026	A. BUILDING: _____ B. WING _____	04/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORONA POST ACUTE CENTER	2600 SOUTH MAIN STREET CORONA, CA 92882

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A 000	Initial Comments The following reflects the findings of the California Department of Public Health during a staffing audit visit for 24 randomly selected days from 07/01/2021 to 09/30/2021. Representing the Department: K.D., Associate Governmental Program Analyst. Health and Safety Code (HSC) section 1276.66 sets forth the Department's authority to conduct audits of direct caregiver nursing services provided to residents of skilled nursing facilities, and to establish procedures for conducting such audits through All Facility Letters (AFLs). <http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1276.66&lawCode=HSC> AFL 21-11, setting forth the audit process and guidelines for facilities is available through the following link: <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-11.aspx> HSC 1337-1338.5, sets forth the requirements for Certified Nurse Assistants is available through the following link: <https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?division=2.&chapter=2.&lawCode=HSC&article=9> HSC section 1276.66 requires the Department to assess an administrative penalty to a SNF if the Department determines that the SNF fails to meet the DHPPD requirements pursuant to HSC sections 1276.5 or 1276.65. The Department shall assess an administrative penalty to any facility that fails to meet the applicable standard for staffing requirements on any given day. The	A 000	The signing, either electronic and/or manual signing, of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan or correction. In fact, this plan of correction is submitted exclusively to comply with State and federal law. The plan of correction serves as the allegation of compliance. Per California Health & Safety Code section 1280(f) "In no event shall the act of providing a plan of correction, the content of the plan of correction, or the execution of a plan of correction, be used in any legal action or administrative proceeding as an admission within the meaning of Sections 1220 to 1227, inclusive, of the Evidence Code against the health facility, its licensee, or its personnel."	

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A 000	Continued From page 1	A 000		

applicable standard is 3.5 DHPPD and 2.4 DHPPD (CNA), unless an approved Workforce Shortage or Patient Needs Waiver is granted.

The statute was not met as evidenced by the following findings:

Final Audit Result:

Total Distinct Non-Compliant Day(s) = 3

Date	3.5	2.4
07/01/2021	4.60	2.72
07/13/2021	4.45	2.70
07/14/2021	4.13	2.50
07/17/2021	3.71	*2.30*
07/27/2021	4.51	2.84
08/03/2021	4.49	2.76
08/18/2021	3.97	2.55
08/24/2021	4.16	2.55
08/26/2021	4.50	2.79
08/27/2021	4.29	2.78
08/29/2021	3.80	2.47
08/30/2021	3.95	2.53
09/01/2021	4.38	2.76
09/02/2021	3.87	2.42
09/04/2021	4.05	2.87
09/05/2021	3.53	2.47
09/06/2021	4.06	2.71
09/07/2021	4.25	2.53
09/08/2021	4.09	2.49
09/09/2021	4.17	2.60
09/14/2021	4.18	2.67
09/21/2021	3.65	*2.31*
09/26/2021	*3.06*	*1.73*
09/30/2021	3.86	2.53

x.xx = non-compliant date

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A 200	Continued From page 2	A 200		
A 200	HSC 1276.65(c)(1)(B) SAS - 3.5 Standard (B) Effective July 1, 2018, skilled nursing facilities, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall have a minimum number of direct care services hours of 3.5 per patient day, except as set forth in Section 1276.9. This Statute is not met as evidenced by: Facility failed to meet 3.5 Direct Care Service Hours Per Patient Day (DHPPD), Pursuant to HSC 1276.65(c)(1)(B) for 1 of 24 days. The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s). Facility failed to maintain current, complete and accurate personnel and payroll records for all employees in accordance with CCR Title 22, section 72533. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees. The Director of Staff Development (DSD) failed to delineate time spent providing nursing services to skilled nursing care patients beyond the hours required to carry out the duties of the DSD position.	A 200	**Immediate measures & systemic changes put into place to ensure that deficient practice does not recur:** The facility will meet 3.5 direct care service hours per patient daypursuant to HSC 1276.65(c) (1) (B). The facility will meet this requirement by: (1) replacing staff either through calling someone in or overtime as need to meet the minimum 3.5 DHPPD staffing requirement, preformed by direct nursing caregivers (2) An in-service was provided on 1/27/25 by the Administrator to the Staffing Coordinator and Director of Staff development (DSD) regarding 3.5 DHPPD, performed by direct nursing caregivers, and calling in staffing/overtime to meet this requirement. **Monitoring process & positions of person responsible for monitoring as well as how the facility plans to monitor its performance to ensure corrections are achieved and sustained:** 3.5 DHPPD will be monitored during daily standup meeting by the Administrator, Director of Nurses, Director of Staff Developer and/or Staffing Coordinator through observation and discuss of projected DHPPD and actual DHPPD, no less than 5 times per week, to ensure facility is sustaining compliance. Findings of the 3.5 DHPPD audit will be reported by the DSD and/or Staffing Coordinator at the QAPI Meeting for 3 months. At that time the QAPI Committee will determine if additional monitoring is required.	1-27-25

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A 205	Continued From page 3	A 205		
A 205	HSC 1276.65(c)(1)(C) SAS - 2.4 Standard (C) Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants in order to meet the requirements in subparagraph (B). This Statute is not met as evidenced by: Facility Failed to meet 2.4 Direct Care Service Hours Per Patient Day (DHPPD) performed by certified nurse assistants, pursuant to HSC 1276.65(c)(1)(C) for 3 out of 24 days. The total number of actual direct care nursing hours performed by direct caregivers per patient day divided by the average census during the patient day failed to meet DHPPD Staffing Standard(s). Facility failed to maintain current, complete and accurate personnel and payroll records for all employees in accordance with CCR Title 22, section 72533. Time spent providing direct care could not be verified. Failure to provide the information has resulted in the exclusion of all service hours for such employees.	A 205	**Immediate measures & systemic changes put into place to ensure that deficient practice does not recur:** The facility will meet 2.4 direct care service hours per patient day, performed by certified nurse assistants, pursuant to HSC 1276.65(c)(1)(C). The facility will meet this requirement by: (1) replacing staff either through calling someone in or overtime as need to meet the minimum 2.4 DHPPD staffing requirement, preformed by certified nursing assistants. (2) An in-service was provided on 1/27/25 by the Administrator to the Staffing Coordinator and Director of Staff development (DSD) regarding 2.4 DHPPD, performed by certified nursing assistants, and calling in staffing/overtime to meet this requirement. **Monitoring process & positions of person responsible for monitoring as well as how the facility plans to monitor its performance to ensure corrections are achieved and sustained:** 2.4 DHPPD will be monitored during daily standup meeting by the Administrator, Director of Nurses, Director of Staff Developer and/or Staffing Coordinator through observation and discuss of projected DHPPD and actual DHPPD, no less than 5 times per week, to ensure facility is sustaining compliance. Findings of the DHPPD audit will be reported by the DSD and/or Staffing Coordinator at the QAPI Meeting for 3 months. At that time the QAPI Committee will determine if additional monitoring is required.	1-27-25
A 020	AFL 21-11 II.B SAS-Form 530 B. Facilities must use CDPH 530. Failure to use this CDPH required form will result in a finding of non-compliance for each audited day the form is not available. The facility is responsible for ensuring all entries are accurate and legible.	A 020		

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A 020	Continued From page 4 This Statute is not met as evidenced by: Facility failed to use CDPH Form 530 per AFL 21-11, Section II, Guidelines, subsection B, and pursuant to W&I 14126.022.	A 020	**Immediate measures & systemic changes put into place to ensure that deficient practice does not recur:** The facility is using CDPH 530 form and will continue using CDPH 530 form per AFL 21-11. Section II, guidelines, subsection B, and pursuant to W&I 14126.022. An in-service was provided on 1/27/25 by the Administrator to the Staffing Coordinator and Director of Staff development (DSD) regarding CDPH 530 form and to meet this requirement. **Monitoring process & positions of person responsible for monitoring as well as how the facility plans to monitor its performance to ensure corrections are achieved and sustained:** Compliance of use of CDPH 530 form will be monitored during daily staffing meeting by the Director of Nurses, Director of Staff Developer through audits no less than 5 times per week, to ensure facility is sustaining compliance. Findings of the audit of CDPH 530 form will be reported by the DON and/or DSD at the QAPI Meeting for 3 months. At that time the QAPI Committee will determine if additional monitoring is required.	1-27-25