Californi	a Department of Public				FOI	RM APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION -A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		CA24000026	B. WING				
NAME OF F	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STA	ATE ZIR CODE] 04	1/18/2022	
CORONA	POST ACUTE CENTER		JTH MAIN STRE				
	TOOT AGOTE CENTER		, CA 92882				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RF.	(X5) COMPLETE DATE	
A 000	Initial Comments		A 000				
nsing and Co	Department of Public audit visit for 24 rando 07/01/2021 to 09/30/2 Representing the Dep Governmental Program Health and Safety Consets forth the Departmental Program audits of direct careging provided to residents of and to establish proces audits through All Facishttp://leginfo.legislatu.playSection.xhtml?section.xhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.yhtml?section.gislatu.playText.xhtml?division=HSC&article=9> HSC section 1276.66 messess an administrativ.Department determinesthe DHPPD requirement sections 1276.5 or 1276.shall assess an administrativorstification Division	partment: K.D., Associate m Analyst. de (HSC) section 1276.66 hent's authority to conduct yer nursing services of skilled nursing facilities, dures for conducting such lity Letters (AFLs). Ire.ca.gov/faces/codes_distionNum=1276.66&lawCod In the audit process and is available through the gov/Programs/CHCQ/LCP/ Is forth the requirements for note is available through the lare.ca.gov/faces/codes_disting=2.&chapter=2.&lawCode equires the Department to ye penalty to a SNF if the sthat the SNF fails to meet his pursuant to HSC 3.65. The Department strative penalty to any if the applicable standard is on any given day. The		The signing, either electronic and/or maigning, of this plan of correction is not dmission or agreement by this facility of the facts alleged in this statement leficiencies and plan or correction. In this plan of correction is submitted exclusively to comply with State and feath. The plan of correction serves as the allegation of compliance. Per California Health & Safety Code served (1280(f) "In no event shall the act of providing a plan of correction, the content he plan of correction, or the execution colan of correction, be used in any legal as or administrative proceeding as an administrative, of the Evidence Code against health facility, its licensee, or its person the state of the content of th	an of the at of act, deral e etion ont of action action ssion 1227, the		
onsing and Co ORATORY DI	ennication Division RECTOR'S OR PROVIDER/SUI	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE		<u> </u>	

NHA

(X6) DATE

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California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED CA240000026 B. WING 04/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2600 SOUTH MAIN STREET **CORONA POST ACUTE CENTER CORONA, CA 92882** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

Californi	a Department of Public	Health			FORM AF	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION		
		IDENTIFICATION NUMBER:	A BUILDING:		(X3) DATE SURVEY COMPLETED	
		CA24000026	B. WING			
AME OF P	ROVIDER OR SUPPLIER			04/18/2022		
			DDRESS, CITY, STA			
ORONA	POST ACUTE CENTER		UTH MAIN STRE A, CA 92882	ET		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE .	(X5) COMPLETE DATE
A 200	Continued From page	2	A 200			
A 200	HSC 1276.65(c)(1)(B)	SAS - 3.5 Standard	A 200			
			1	nmediate measures & systemic chang	es	
	(B) Effective July 1, 2018, skilled nursing			at into place to ensure that deficient		
	that are a distinct next	skilled nursing facilities	p	ractice does not recur:	1	
ļ	facility or a state-owner	of a general acute care	<u> </u>	ne facility will meet 3.5 direct care serv	ice	
	developmental center	shall have a minimum	j h	ours per patient daypursuant to HSC		
1	number of direct care	services hours of 3.5 per	[4	276.65(c) (1) (B).	ļ	
	patient day, except as	set forth in Section 1276.9.	71	ne facility will meet this requirement by		
				replacing staff either through calling	•	
				meone in or overtime as need to meet the	ne	
				inimum 3.5 DHPPD staffing requireme		
	This Statuta is not well			eformed by direct nursing caregivers		
	This Statute is not met as evidenced by: Facility failed to meet 3.5 Direct Care Service) An in-service was provided on 1/27/25		
Hours Per Patient Day		(DHPPD), Pursuant to		e Administrator to the Staffing Coordina		
	HSC 1276.65(c)(1)(B)	for 1 of 24 days		d Director of Staff development (DSD)		
				garding 3.5 DHPPD, performed by dire irsing caregivers, and calling in	ct	
1.	- 1			affing/overtime to meet this requirement	t.	
١.	The total number of act	tual direct care nursing		series to most one redomenter.	•	
[]	Tours performed by dire	ect caregivers per patient	M	onitoring process & positions of perso	on	
;	day divided by the aver patient day failed to me	age census during the		sponsible for monitoring as well as ho	w	
5	Standard(s),	et DHPPD Statting		e facility plans to monitor its		
	` '			erformance to ensure corrections are		
F	acility failed to maintai	n current, complete and		hieved and sustained: 5 DHPPD will be monitored during dail		
-	iccurate personnel and	Davroil records for all		andup meeting by the Administrator,	У	
e	imployees in accordance	Ce with CCR Title 22		rector of Nurses, Director of Staff	1	
S	ection 72533. Time spe	ent providing direct care	[D	eveloper and/or Staffing Coordinator	}	
0	ould not be verified. Fa	allure to provide the	th:	rough observation and discuss of project		
(I	nformation has resulted	In the exclusion of all		HPPD and actual DHPPD, no less than :	5	
3	ervice hours for such e	mpioyees.		nes per week, to ensure facility is		
T	he Director of Staff De	velopment (DSD) failed to	su	staining compliance.		
d	elineate time spent pro	velopment (DSD) falled to viding nursing services to	D:	ndings of the 3.5 DHPPD audit will be		
SI	diled nursing care patie	ents beyond the hours		ported by the DSD and/or Staffing		
re	equired to carry out the	duties of the DSD		pordinator at the QAPI Meeting for 3	1-2	7-25
po	osition.			onths. At that time the QAPI Committee		-
		ľ		Il determine if additional monitoring is	·	
				quired,	ĺ	

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ CA240000026 04/18/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2600 SOUTH MAIN STREET CORONA POST ACUTE CENTER CORONA, CA 92882** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) A 205 A 205 Continued From page 3 Immediate measures & systemic changes A 205 HSC 1276.65(c)(1)(C) SAS - 2.4 Standard A 205 put into place to ensure that deficient practice does not recur: (C) Skilled nursing facilities shall have a minimum he facility will meet 2.4 direct care service of 2.4 hours per patient day for certified nurse hours per patient day, performed by certified assistants in order to meet the requirements in nurse assistants, pursuant to HSC 1276.65(c) subparagraph (B). (1) (C). The facility will meet this requirement by: (1) replacing staff either through calling someone in or overtime as need to meet the This Statute is not met as evidenced by: rhinimum 2.4 DHPPD staffing requirement, Facility Failed to meet 2.4 Direct Care Service preformed by certified nursing assistants. Hours Per Patient Day (DHPPD) performed by (2) An in-service was provided on 1/27/25 by certified nurse assistants, pursuant to HSC the Administrator to the Staffing Coordinator 1276.65(c)(1)(C) for 3 out of 24 days. and Director of Staff development (DSD) regarding 2.4 DHPPD, performed by dertified nursing assistants, and calling in The total number of actual direct care nursing staffing/overtime to meet this requirement. hours performed by direct caregivers per patient day divided by the average census during the Monitoring process & positions of person patient day failed to meet DHPPD Staffing responsible for monitoring as well as how Standard(s). the facility plans to monitor its performance to ensure corrections are Facility failed to maintain current, complete and achieved and sustained: accurate personnel and payroll records for all 2.4 DHPPD will be monitored during daily employees in accordance with CCR Title 22, standup meeting by the Administrator, section 72533. Time spent providing direct care Director of Nurses, Director of Staff could not be verified. Failure to provide the Developer and/or Staffing Coordinator information has resulted in the exclusion of all through observation and discuss of projected service hours for such employees. DHPPD and actual DHPPD, no less than 5 times per week, to ensure facility is sustaining compliance. A 020 A 020 AFL 21-11 II.B SAS-Form 530 Findings of the DHPPD audit will be B. Facilities must use CDPH 530. Failure to use reported by the DSD and/or Staffing this CDPH required form will result in a finding of Goordinator at the QAPI Meeting for 3 non-compliance for each audited day the form is 1-27-25 months. At that time the QAPI Committee not available. The facility is responsible for will determine if additional monitoring is ensuring all entries are accurate and legible. required.

Licensing and Certification Division

ROK511

Californi	a Department of Public	Health			FORM APPROVE	
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		CA240000026	B. WING		04/40/0000	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE ZIP CODE	04/18/2022	
CORONA	POST ACUTE CENTER		OUTH MAIN STR			
	1	CORON	IA, CA 92882			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
A 020	Continued From page	9 4	A 020			
	This Statute is not me Facility failed to use O	et as evidenced by: CDPH Form 530 per AFL delines, subsection B, and		Immediate measures & systemic chan put into place to ensure that deficient practice does not recur: The facility is using CDPH 530 form awill continue using CDPH 530 form per 21-11. Section II, guidelines, subsection and pursuant to W&I 14126.022. An in-service was provided on 1/27/25 the Administrator to the Staffing Coordinand Director of Staff development (DSI regarding CDPH 530 form and to meet a requirement. Monitoring process & positions of per responsible for monitoring as well as the facility plans to monitor its performance to ensure corrections are achieved and sustained: Compliance of use of CDPH 530 form whe monitored during daily staffing meet by the Director of Nurses, Director of Stimes per week, to ensure facility is sustaining compliance. Findings of the audit of CDPH 530 form be reported by the DON and/or DSD at QAPI Meeting for 3 months. At that tin QAPI Committee will determine if additing monitoring is required.	AFL B, Dy nator his son now vill ng taff will he he he the \-23-2	