STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055045	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riviera Healthcare Center	8203 Telegraph Rd Pico Rivera, CA 90660

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36331 Based on interview and record review, the facility failed to readmit one of three sampled residents (Resident 1), who was transferred to a General Acute Care Hospital (GACH) for refusal of care at the facility and was deemed appropriate to return to the facility. This deficient practice placed the resident at risk for confusion and psychosocial harm related to the inability to return to the facility and unnecessary, extended stay at the GACH. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including cellulitis (a skin infection that causes swelling and redness) of the buttock and left lower limb, type two diabetes mellitus ([DM[a disorder characterized by difficulty in blood sugar control), and pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of the right. The admission record indicated Resident 1 was self-responsible. During a review of Resident 1's Initial assessment dated [DATE] at 7:30 p.m., the assessment indicated Resident 1 spoke English, was alert and oriented to person, place, and time (x3), friendly, cooperative and had good motivation toward rehabilitation. The assessment indicated Resident 1 had multiple opened lesions on the left lower extremity due to cellulitis and an unstageable pressure injury on the sacrum (tailbone) area. During a review of Resident 1's Order Summary Report, dated 10/17/2024, the Report indicated Resident 1 was admitted to the facility for skilled nursing services. The Report indicated administer Cephalexin (medication to treat infection) 500 milligrams ([mg] a unit of measurement) three (3) times a day for 14 days (until 10/31/2024), for cellulitis of the left lower extremity and Flagyl (medication to treat infection) 500 mg, 1 tablet every 12 hours until 10/30/2024 for cellulitis of the lower extremity. The Report indicated Resident 1 may have rehabilitation (process that helps people regain or improve physical abilities needed for daily life) screening upon admission. The Report did not any wound care orders for Resident 1. (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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's PT (Physical Therapy) Evaluation and Plan of Treatment dated, 10/18/2024, the PT Plan of Treatment indicated resident 1 was bitten by a pit bulldog and had extensive wound to his leg. The Plan of Treatment indicated Resident 1 did not test for ambulation (walking) due to his extensive wound (wound healing) on left leg and its pain at the time of the evaluation. The Plan of Treatment indicated Resident 1 required skilled PT services to increase independence with gait (how resident moves), facilitate functional mobility, promote safety awareness, increase functional activity tolerance. During a review of Resident 1's Medication Administration Record (MAR) dated 10/2024, the MAR indicated Resident 1 refused Flagyl 500 mg. 1 tablet by mouth and Cephalexin 500 mg. tablet by mouth on 10/17/2024. The MAR indicated Resident 1 received Flagyl as ordered on 10/18/2024 at 9:00 a.m. and Cephalexin as ordered on 10/18/2024 at 9:00 a.m. and 1:00 p.m. During a review of Resident 1's interdisciplinary Team Meeting ([IDT] a group of professionals from different disciplines and specialties collaborating to provide residents with needed care) dated 10/18/2024, the IDT indicated Resident 1 refused to be taken care of and refused wound care. The IDT indicated the importance and benefits of compliance with care and following the physician's orders were explained to Resident 1. The IDT did not indicate Resident 1 was assessed for reasons why he refused care or if he was provided alternative options. During a review of Resident 1's Change of Condition (COC), dated 10/18/2024, the COC indicated Resident 1 was a new admit (on 10/17/2024) and refused treatment, to be touched, activities of daily living (ADLs), wound care and wound care. The COC indicated the risks and benefits were explained to Resident 1, but resident still refused. The COC indicated Resident 1's physician was notified on 10/18/2024 at 12:50 p.m. with an order to transfer Resident 1 to GACH. During a review of Resident 1's GACH faxed inquiry documents (clinical records supporting a resident's readiness for hospital discharge) dated 10/22/2024, the documents indicated Resident 1 was medically stable to be transferred back to the facility for continuation of physical therapy (PT), occupational therapy (OT), wound care, and oral antibiotics. The documents indicated Resident 1 had agreed to go back to the facility or any other facility if he was being treated for pain and cellulitis. During an interview on 10/28/2024 at 1:04 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated, Resident 1 was offered a shower (on 10/18/2024). Resident requested a basin of soapy water and towels instead and preferred to do things by himself. CNA 1 stated, she assisted Resident 1 to the wheelchair. During an interview on 10/28/2024 at 1:40 p.m., with Physical Therapist (PT) 1, PT 1 stated she completed the PT evaluation on Resident 1 on (10/18). PT 1 stated, Resident 1 refused the walking evaluation because of the resident's leg wound, however the resident was cooperative and perfectly okay during the evaluation. During an interview on 10/28/2024 at 1:50 p.m., with Treatment Nurse (LVN 3), LVN 3 stated, he assessed Resident 1 on 10/18/2024. LVN 3 stated, Resident 1 allowed LVN 3 to look at his wounds. LVN 3 stated, Resident 1 stated, the wounds on his legs and buttocks were much better and no one was going to do anything about it. LVN 3 stated he did not have treatment orders for Resident 1's wound care. LVN 3 stated, Resident 1 was not combative. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/28/2024 at 3:59 p.m. with the DON, Resident 1's GACH faxed inquiry documents, dated 10/22/2024 were reviewed. The DON stated even though Resident 1 agreed to return to the facility, the facility would not take Resident 1 back because Resident 1 had refused some care. During a review of the facility's Facility Assessment (a complete review of internal human and physical resources required by the facility to care for residents competently during day to day and emergency operations and identify the capabilities of a skilled nursing services provider), dated 10/22/2024, the facility assessment indicated its mission was to create a compassionate environment for each person entrusted to the facility's care and to inspire hope and healing by helping those individuals achieve their highest level of physical, emotional, and spiritual well-being. The facility assessment indicated the facility could care for residents with diagnoses including infections, and skin wounds and pressure ulcers. The facility assessment indicated the facility had followed mandated requirements for training, including: Person-centered care- which included but not limited to person-centered care planning, education of resident and family/resident representative about treatments and medications, documentation of resident treatment preferences, and advance care planning. Resident's Care Conference and Care Plans - involving resident, Resident Representative, and direct care staff. Prevention and management of pressure injury, wound management, skin care, surgical incision, arterial, venous ulcer consultation with a specialist (dermatology, podiatry, wound etc.). The resident will not develop pressure injury or other skin conditions unless it's unavoidable and related to the resident's medical condition, co morbidity and risk factors. Behavior management. IDT will develop and implement interventions in managing resident's behavior and to help support individuals dealing with anxiety, cognitive impairment, depression. During a phone interview on 10/29/2024 at 3:20 p.m. with the GACH's Social Worker (GACH 1 SW), the GACH 1 SW stated Resident 1 agreed to go back to the facility, but the facility did not provide the reasons why the facility was not taking Resident 1 back. During an interview on 10/29/2024 at 4 p.m. with the Director of Nursing (DON), the DON stated the facility had beds available when the inquiry came from the GACH 1. The DON stated the facility was able to provide wound care and therapy. The DON stated she did review the inquiry she received from the GACH because the IDT had decided the facility was not going to take Resident 1 back. The DON stated the moment Resident 1 refused the bed hold and refused to be in the facility, the facility would respect Resident 1's decision. The DON stated since Resident 1 did not have a bed hold and was in the facility for less than 24 hours, Resident 1 was not the facility's resident. The DON also stated there was not enough time to get to know the resident in less than 24 hours. During an interview on 10/30/2024 at 10:38 a.m. with the administrator (ADM), the ADM stated on 10/19/2024 the IDT decided Resident 1 will not be readmitted back to the facility because Resident 1 wanted to leave the facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/5/2024 at 1:25 p.m. with Registered Nurse (RN 1), the IDT, dated 10/18/2024 was reviewed. RN 1 stated the IDT met with Resident 1 regarding the resident's refusal of care and had asked why he refused care but Resident 1 kept stating no one touched him nor go near him. RN 1 stated they did not give alternatives to Resident 1 because Resident 1 did not want anybody and did not complain of anybody specific and he did not have any concerns about his care, just that he did not want to be touched. During a concurrent interview and record review on 11/5/2024 at 1:40 p.m. with the DON, the facility's Facility Assessment, dated 10/22/2024 was reviewed. The DON stated, the facility assessment indicated the facility could care for residents with diagnoses including infections, skin wounds, pressure ulcers and had training for behavior management. The DON stated Resident 1's refusal of care was not considered a behavior and the facility could not take care of a resident that was refusing everything. The DON stated the IDT determined not to take Resident 1 back to the facility because Resident 1 did not let the facility perform care. During a review of the facility's Policy and Procedure (P&P) titled, Admission Criteria, dated 12/2016, the P&P indicated, Residents would be admitted to the facility as long as their nursing and medical needs could be met by the facility. The P&P indicated examples of conditions that can be treated adequately in the facility include, DM. The P&P indicated examples of nursing/medical needs that could be met adequately included: medication management, limited mobility, incontinence. During a review of the facility's P&P titled, Bed-Holds and Returns, dated 1/2024, the P&P indicated, if the resident refused bed hold with the expectation that he or she would not return, the resident would be formally discharged . The P&P indicated the resident would be permitted to return to an available bed in the location of the facility that he or she previously resided. The P&P indicated, if there is no available bed, the resident will be given option to take an available bed in another distinct part of the facility and return to the previous distinct part when a bed becomes available.