

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Riviera Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on interview and record review, the facility failed to notify the primary care physician (PCP), when one of five sampled residents (Resident 2), refused to receive wound care.</p> <p>This failure placed Resident 2 ' s wounds at risk for delayed healing and had the potential for complications such as severe infection, hospitalization , and death, because of the refusal.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s Admission Record, the Admission Record indicated, Resident 2 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Resident 2 ' s diagnoses included encounter for orthopedic (a branch of medicine that focuses on injuries and diseases of the musculoskeletal system) aftercare following surgical amputation (a surgical procedure to remove a limb or other body part).</p> <p>During a review of Resident 2 ' s Minimum Data Set ([MDS], a federally mandated resident assessment tool) dated, 12/12/2024, the MDS indicated Resident 2 was cognitively intact (having the ability to think, remember, and solve problems). The MDS indicated Resident 2 was dependent (helper does all the effort) for Activities of Daily Living (ADLs) such as toileting hygiene and required substantial/maximal assistance (helper does more than half the effort) to perform ADLs of lower body dressing and putting on/off footwear.</p> <p>During a review of Resident 2 ' s Treatment Administration Record (TAR) for January 2025, the TAR indicated the following treatment administration orders:</p> <p>a. Left Below Knee Amputation (BKA) surgical: cleanse with normal saline (NS), pat dry, paint with betadine solution, and cover with dry dressing then wrap with kerlix every day and as needed if soiled/dislodged for 21 days, start date on 1/4/2025.</p> <p>b. Left BKA: cleanse with normal saline (NS), pat dry, paint with betadine solution, and cover with dry dressing then wrap with kerlix (a type of bandage) every day and as needed if soiled/dislodged for 21 days, started on 1/26/2025.</p> <p>c. Right lower leg: cleanse with normal saline, pat dry paint with betadine solution, leave open to air every day shift for diffuse scabs for 21 days, started on 1/26/2025.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>d. Abdomen multiple scattered, discolorations: monitor for skin integrity every day every shift for 21 days, started on 1/1/2025.</p> <p>e. Left Posterior (back) upper arm multiple scattered purplish discolorations: monitor for skin integrity every day, every day shift for 21 days, started on 1/5/2025.</p> <p>f. Perianal (located near the opening of the rectum to the body): cleanse with normal saline, pat dry, apply zinc oxide every day shift for moisture-associated skin damage (MASD) for 21 days, started on 1/5/2025.</p> <p>g. Perineal (area of skin between the anus and external genitalia): cleanse with normal saline, pat dry, apply zinc oxide every day shift for MASD for 21 days, started on 1/5/2025.</p> <p>During a concurrent interview and record review on 2/21/2025 at 1:27 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 2 ' s TAR for 1/2025 was reviewed. LVN 3 stated the TAR indicated Resident 2 had refused all wound care on 1/5/2025. LVN 3 stated Resident 2 ' s physician was not of Resident 2 ' s refusal of wound care.</p> <p>During an interview on 2/21/2025 at 1:51 p.m. with the Director of Nursing (DON), the DON stated Resident 2 ' s physician should have been notified when Resident 2 refused all wound care on 1/5/2025 because it could jeopardize Resident 2 ' s health.</p> <p>During a review of facility's policy and procedure (P&P titled), Requesting, Refusing and/or Discontinuing Care or Treatment, dated 12/2024, P&P indicated documentation pertaining to a resident ' s refusal of treatment should include at least the date and time the practitioner was notified as well as the practitioner's response.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48778</p> <p>Based on observation, interview and record review, the facility failed to implement its policy and procedure (P&P) titled, Isolation - Categories of Transmission Based Precautions (additional infection control measures used for residents who may have a contagious disease), for two out of five residents (Residents 3 and 4) by failing to:</p> <p>a. Ensure staff wore personal protective equipment ([PPE] protection equipment that includes face shields, gloves, goggles and glasses, gowns, head covers, masks, respirators, and shoe cover to protect against the transmission of germs through contact and droplet routes) prior to entering a contact isolation (a type of infection control precaution used to prevent the spread of infectious diseases that are transmitted through direct or indirect contact with the patient or their environment) room and while inside a contact isolation room.</p> <p>b. Ensure staff discarded used PPE in designated receptacles prior to exiting a contact isolation room.</p> <p>These deficient practices had the potential to increase the risk of transmitting disease-causing organisms to other residents and staff, leading to illnesses.</p> <p>Findings:</p> <p>a. During an observation on 2/20/2025 at 12:49 p.m., a contact isolation sign was observed outside the door of Resident 3's room. A Certified Nursing Assistant (CNA) 1 was observed feeding Resident 3 without wearing a gown.</p> <p>During a concurrent observation and interview on 2/20/2025 at 12:54 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated CNA 1 should be wearing a gown and gloves when providing care for Resident 3, to prevent transmitting organisms that Resident 3 has.</p> <p>During a concurrent observation and interview on 2/20/2025 at 12:55 p.m. with CNA 1 outside of Resident 3's room, CNA 1 stated that the isolation sign outside Resident 3's room indicated type of PPE staff should wear when entering the isolation room and while in the isolation room. CNA 1 stated she should have worn an isolation gown.</p> <p>During a review of Resident 3's Admission Record, the Admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of acute respiratory failure ([ARF] a life-threatening condition where there is not enough oxygen or too much carbon dioxide in the body) with hypoxia (an insufficient amount of oxygen in the body's tissues or blood).</p> <p>During a review of Resident 3's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 2/21/2025, the MDS indicated Resident 3 had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgment, and make decisions).The MDS indicated Resident 3 was dependent (helper does all of the effort) to perform Activities of Daily Living (ADL)s such as lower body dressing and showering/bathing self.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3's Order Summary Report (a list of current doctor's orders), dated 2/19/2025, the Order Summary Report indicated to place Resident 3 on contact isolation due for candida auris ([C auris], a fungal infection that can cause serious illness).</p> <p>b. During a concurrent observation and interview on 2/20/2025 at 1:22 p.m., CNA 3 was observed entering Resident 4's room without any PPE that had a contact isolation sign by the door. CNA 3 was observed stepped out of Resident 4's room, and reentered, without the use of a PPE. CNA 3 stated she should have put on isolation gown and gloves when in a contact isolation room.</p> <p>During an observation on 2/20/2025 at 1:26 p.m., CNA 3 left Resident 4's room with the used isolation gown in her hand.</p> <p>During a review of Resident 4's Admission Record, the Admission Record indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of urinary tract infection ([UTI], an infection in the bladder/urinary tract).</p> <p>During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had no cognitive impairment. The MDS indicated Resident 4 was dependent to perform ADLs such as toileting hygiene and showering/bathing self.</p> <p>During a review of Resident 4's Order Summary Report, dated 2/20/2025, the Order Summary Report indicated to place Resident 4 on contact isolation due to diagnosis of extended-spectrum beta-lactamase ([ESBL] a bacterium that is resistant to antibiotics) in the urine until 2/22/2025 at 11:59 p.m.</p> <p>During an interview on 2/20/2025 at 2:00 p.m. with LVN 2, LVN 2 stated used isolation gowns should be discarded in the resident's room prior to leaving. LVN 2 stated that CNA 3 should not have walked out of the room with the dirty gown on her hand because Resident 4 was on isolation and the isolation gown had been contaminated.</p> <p>During an interview on 2/25/2025 at 1:51 p.m. with the Director of Nursing (DON), the DON stated that staff should wear PPE and use proper hand washing to protect other staff and other residents. The DON described PPE as a way to prevent the spread of infection while taking care of a resident in a contact isolation room.</p> <p>During a review of the facility's P&P titled, Isolation - Categories of Transmission Based Precautions, dated 1/2025, the P&P indicated transmission-based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. The P&P indicated for contact precautions, in addition to standard precautions, gloves and disposable gowns should be used upon entering the contact precaution room. The P&P indicated, after the gown had been removed, to not allow clothing to contact potentially contaminated environmental surfaces or items in the resident's room.</p>		