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	02/27/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to maintain a safe and hazard free environment for two of three sampled residents (Resident 1 and Resident 2), when: 1. Licensed Vocational Nurse (LVN) 1 left Resident 1 unattended and unsupervised at Nurse's Station 3, on 2/14/2025. 2. Activity Staff (AS) 3 left Resident 1 at Nurse's Station 3, without verifying there was a charge nurse present to supervise Resident 1, on 2/14/2025. 3. On 2/25/2025, Resident 1 did not have bilateral fall mats (a cushioned floor pad designed to help prevent injury should a person fall) at her bedside, as ordered by the physician. 4. On 2/25/2025, Resident 1 did not have fall risk indicators outside of her room, or on her Geri-chair (a large, padded chair with a wheeled base, designed to assist individuals with limited mobility), in accordance with Resident 1's care plan. 5. A Morse Fall Scale assessment (a clinical assessment tool used to predict a patient's risk of falling) was not conducted following Resident 2's fall on 12/25/2024. 6. On 2/26/2025, Resident 2 did not have fall risk indicators outside of her room, or on her wheelchair, in accordance with Resident 2's care plan. These deficient practices resulted in Resident 1 falling on 2/14/2025 and sustaining a displaced subcapital left femoral neck fracture (a broken bone in the upper part of the left thigh bone, where the broken pieces are significantly displaced from their normal position) requiring surgical intervention in a general acute care hospital (GACH). These deficient practices also placed Resident 1 and Resident 2 at risk for further falls and fall related injuries. Findings: (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

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 02/27/2025
NAME OF PROVIDER OR SUPPLIER Riviera Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 8203 Telegraph Rd Pico Rivera, CA 90660	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was most recently readmitted to the facility on [DATE]. Resident 1's admitting diagnoses, as of 2/18/2025, included generalized muscle weakness, left thigh bone fracture, history of falling, dementia (a progressive state of decline in mental abilities), epilepsy (a chronic brain disorder characterized by recurrent seizures, which are brief episodes of abnormal brain activity that can cause involuntary movements, loss of consciousness, or other symptoms), and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 1's History and Physical (H&P), dated 1/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P did not indicate diagnoses of osteoporosis or osteopenia (a condition characterized by low bone mineral density, which makes bones weaker and more prone to fractures). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/13/2025, the MDS, indicated Resident 1 had memory problems and severely impaired cognition (a significant decline in cognitive abilities that interferes with daily life and independence). The MDS indicated Resident 1 had impairments to her lower extremities (hip, knee, ankle, and foot) on both sides of her body. The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. The MDS indicated diagnoses of lack of coordination and generalized muscle weakness. During a review of Resident 1's care plan titled At risk for fall, dated 1/10/2025, the care plan indicated staff were to provide frequent visual monitoring of Resident 1 to reduce the risk of falls and/or injury. During a review of Resident 1's Morse Fall Scale Assessment, dated 1/11/2025, the assessment indicated Resident 1 was at high risk for falls due to impaired gait (an abnormal walking pattern), and overestimation (judging something too highly), and/or forgetfulness of her ability to walk safely. During a review of Resident 1's Change of Condition (COC) assessment, dated 2/14/2025 at 3:10 PM, the COC indicated on 2/14/2025 Resident 1 had a witnessed fall, in the hallway. The COC indicated Resident 1 reported a 4 out of 10 pain (0: no pain, 1 to 3: mild pain, 4 to 6: moderate pain, and 7 to 10: severe pain) to her left hip. The COC indicated Resident 1 was administered Tylenol 650 milligrams (mg, a unit of dose measurement) for pain. The COC indicated Resident 1's physician was notified of the fall and the physician ordered for an immediate x-ray (a procedure that uses radiation to create images of the inside of the body) to rule out broken bones. During a review of the facility record titled Investigation Statement, dated 2/14/2025 at 3:10 PM, the record indicated a handwritten statement by Licensed Vocational Nurse (LVN) 1 regarding Resident 1's fall on 2/14/2025. The record indicated on 2/14/2025 (no time specified), Resident 1 was sitting in a wheelchair near the nurse's station. The record indicated LVN 1 was assisting another resident in the hallway when Resident 1 fell . (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

During a review of Resident 1's COC assessment, dated 2/14/2025 at 9:45 PM, the COC indicated the x-ray revealed Resident 1 had an acute (severe and sudden in onset) left thigh bone fracture related to a witnessed fall. The COC indicated Resident got up unassisted and lost her balance. The COC indicated Resident 1 reported an 8 out of 10 pain. The COC indicated staff administered Norco 5/325 mg (a combination medication used to relieve severe pain when other pain medication was insufficient) for pain. The COC indicated Resident 1's physician gave an order for the resident to be a transferred to a GACH for evaluation and treatment of the left thigh bone fracture.

During a review of Resident 1's progress note, dated 2/14/2025 at 11:45 PM, the progress note indicated Resident 1 was transferred to the GACH on 2/14/2025 at 11:30 PM.

During a review of Resident 1's GACH record titled History and Physical, dated 2/15/2025 (untimed), the record indicated Resident 1 was brought to the GACH after falling onto her left side while trying to walk. The record indicated a plan to admit Resident 1 to the medical-surgical unit (a unit for patients recovering from surgery, preparing for surgery, or managing various medical conditions).

During a review of Resident 1's GACH record titled Radiology Report, dated 2/15/2025 at 2:23 AM, the record indicated an x-ray was taken of Resident 1's left hip. The record indicated Resident 1 had a displaced subcapital left femoral neck fracture.

During a review of Resident 1's facility progress note, dated 2/15/2025 at 1:42 PM, the progress note indicated Resident 1 was admitted to the GACH and in the process of being referred to, and evaluated by, an orthopedic physician (a physician who treats injuries and diseases involving muscles, bones, joints, ligaments, and tendons) for a possible left hip hemiarthroplasty (surgical replacement of half of the hip joint) related to her fracture.

During a review of Resident 1's GACH record titled Discharge Summary Notes, dated 2/17/2025 at 8:07 AM, the record indicated a final diagnosis of acute left femoral neck fracture. The record indicated Resident 1's conservator (a person appointed by a court to manage her care) declined to provide consent for orthopedic surgery (a surgical procedure on the musculoskeletal system), and Resident 1 was to be discharged back to the facility.

During a review of Resident 1's facility progress note, dated 2/18/2025 at 11:45 AM, the progress note indicated Resident 1 was readmitted to the facility on [DATE].

During a review of Resident 1's medical record titled Routine Pain Assessment Flowsheet, undated, and Pain Assessment Flowsheet, undated, the records indicated Resident 1 received Norco 5/325 mg for the following pain levels:

1. On 2/20/2025 at 3:00 AM: 7/10 pain to her left lower extremity (leg).

2. On 2/20/2025 at 9:00 AM: 8/10 pain to her left lower extremity.

3. On 2/21/2025 at 5:00 AM: 7/10 pain to her left lower extremity.

4. On 2/21/2025 at 11:30 AM: 7/10 pain to her left lower extremity.

5. On 2/22/2025 at 9:00 AM: 8/10 pain to her left lower extremity.

(continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	6. On 2/22/2025 at 2:00 PM: 8/10 pain to her left lower extremity. 7. On 2/24/2025 at 9:00 AM: 8/10 pain to her left lower extremity. 8. On 2/25/2025 at 9:00 AM: 7/10 pain to her left lower extremity. 9. On 2/27/2025 at 9:00 AM: 8/10 pain to her left lower extremity. 10. On 2/27/2025 at 2:30 PM: 7/10 pain to her left lower extremity. During a telephone interview on 2/26/2025 at 9:14 AM, with LVN 1, LVN 1 stated she was Resident 1's Charge Nurse the afternoon of 2/14/2025, and was aware Resident 1 was at risk for falls. LVN 1 stated she was supervising Resident 1 at the nurse's station and there were no other staff present when Resident 1 fell . LVN 1 stated she did not ask any staff member to supervise Resident 1 before leaving the resident unattended at the nurse's station. LVN 1 stated she was down the hall from Resident 1, with her back towards the resident, when she heard Resident 1's wheelchair alarm. LVN 1 stated she turned around and saw Resident 1 standing up and holding onto the armrest of her wheelchair for support. LVN 1 stated she was too far away from Resident 1 to intervene, and she observed Resident 1 fall to the ground onto her left side. LVN 1 stated Resident 1 denied any pain during the shift, prior to the fall, but complained of pain to her left hip after the fall. LVN 1 stated she should not have left Resident 1 unattended and unsupervised at the nurse's station. LVN 1 stated the fall could have been prevented if Resident 1 was not left unsupervised. During a telephone interview on 2/26/2025 at 4:43 PM, with Registered Nurse (RN) 1, RN 1 stated Resident 1's care plan intervention of frequent visual monitoring meant Resident 1 should not be left unattended. RN 1 stated to implement this intervention, Resident 1 should always be within a supervising staff member's line of sight. RN 1 stated leaving a resident who required frequent visual monitoring unattended could result in a fall and injury. During a concurrent interview and record review, on 2/27/2025 at 1:02 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, revised 1/2025, was reviewed. The DON stated the P&P indicated resident supervision was a core component for resident safety. The DON stated LVN 1 should not have left Resident 1 unattended because Resident 1 was known as a high risk for falls. The DON stated LVN 1 should have ensured another staff was supervising Resident 1, before leaving the resident at the nurse's station. 2. During a review of the facility record titled Investigation Statement, dated 2/18/2025, untimed, the record indicated a handwritten statement by Activity Staff (AS) 1 regarding Resident 1's fall on 2/14/2025. The record indicated on 2/14/2025 (time unspecified) Resident 1 was in the dining room requesting to be taken back to her room. The record indicated an unidentified staff wheeled Resident 1 to an unspecified nurse's station. During a concurrent interview and record review, on 2/25/2025 at 1:03 PM, with AS 1, the facility record titled Investigation Statement, dated 2/18/2025 (time unspecified), was reviewed. AS 1 stated the staff member who took Resident 1 to the nurse's station was identified as AS 3. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/25/2025 at 2:11 PM, with AS 3, AS 3 stated in the afternoon, of 2/14/2025, she took Resident 1 from the dining room to Nurse's Station 2 for supervision because the resident was at risk for falls. AS 3 stated she parked Resident 1's wheelchair at the nurse's station and informed an unidentified individual, who was sitting at the nurse's station, that she (AS 3) was leaving Resident 1 there. AS 3 stated she assumed the individual at the nurse's station was a nurse and (she) returned to the dining room. AS 3 stated she could not state the name of the individual who was sitting at the nurse's station, and did not verify the individual was Resident 1's Charge Nurse. During a telephone interview on 2/26/2025 at 9:14 AM, with LVN 1, LVN 1 stated she was Resident 1's Charge Nurse the afternoon of 2/14/2025. LVN 1 stated she did not recall being notified by AS 3 that Resident 1 was at Nurse's Station 3 for supervision. During a concurrent interview and record review, on 2/27/2025 at 1:02 PM, with the DON, the facility's P&P titled Falling Star Program, revised 1/2025, was reviewed. The DON stated the P&P indicated staff were required to inform the Charge Nurse whenever a resident was transferred to a supervised area, including the nurse's station. The DON stated clinical staff (directly related to patient care) and non-clinical staff (not directly providing care or treatment) both had access to and sometimes sat at the nurse's stations. The DON stated it was not safe to assume an individual was a licensed nurse because they were seated at the nurse's station. The DON stated AS 3 should have verified Resident 1's Charge Nurse was aware Resident 1 was being left at the nurse's station. The DON stated this would ensure Resident 1 received adequate supervision by a qualified staff person. The DON stated lack of supervision placed Resident 1 at risk for falls. 3. During a review of Resident 1's care plan titled At risk for fall, dated 1/10/2025, the care plan interventions indicated Resident 1 was to have bilateral floor mats to minimize potential injury from falls. During a review of Resident 1's active physician order, dated 2/18/2025, the order indicated Resident 1 was required to have bilateral floor mats to minimize potential injury from falls. During an observation on 2/25/2025 at 1:43 PM, at Resident 1's bedside, Resident 1 was observed lying in bed . No fall mats were observed at Resident 1's bedside. During a concurrent observation and interview on 2/25/2025 at 2:32 PM, at Resident 1's bedside, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 did not have fall mats to either side of her bed. CNA 1 stated Resident 1 did not have fall mats the entire day. CNA 1 stated the purpose of the fall mats was to prevent or minimize risk of injury from a fall. During a concurrent interview and record review, on 2/27/2025 at 1:09 PM, with the DON, Resident 1's physician order dated 2/18/2025, and a photo of Resident 1's room and bedside, taken 2/25/2025 at 1:52 PM, were reviewed. The DON stated the physician order indicated Resident 1 should have bilateral floor mats at her bedside. The DON stated the photo indicated Resident 1 did not have bilateral floor mats as ordered. The DON stated Resident 1 was at risk for injury because the fall mats were not available to reduce the impact of a fall. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	4. During a review of Resident 1's care plan titled Falling Star Program ., dated 2/14/2025, the care plan indicated Resident 1 was to have two yellow star-shaped indicators on her wheelchair and outside of her room by her nameplate. During an observation on 2/25/2025 at 1:52 PM, outside of Resident 1's room, Resident 1's nameplate affixed to the wall outside the resident's room did not have star-shaped indicators next to Resident 1's name. During a concurrent observation and interview on 2/25/2025 at 2:35 PM, with CNA 1, in the hallway outside of Resident 1's room, Resident 1's Geri-chair did not have any star-shaped indicators attached to it. CNA 1 stated the star-shaped indicators alerted staff that a resident was at risk for falls. CNA 1 stated Resident 1 used a Geri-chair instead of a wheelchair because she had left thigh bone fracture. During a concurrent observation and interview on 2/25/2025 at 2:39 PM, with CNA 1, the nameplate outside of Resident 1's room was observed. CNA 1 stated Resident 1 did not have any star-shaped indicators next to the resident's name to indicate Resident 1 was a fall risk. During a concurrent interview and record review, on 2/27/2025 at 1:11 PM, with the DON, Resident 1's care plan titled Falling Star Program ., dated 2/14/2025, and the facility's P&P titled Falling Star Program, dated 1/2025, were reviewed. The DON stated the care plan and P&P indicated Resident 1 was required to have two star-shaped indicators next to her name on the nameplate outside of her room, and on her wheelchair and/or Geri-chair. The DON stated the purpose of the star-shaped indicators was to provide a visual reminder to staff of the resident's fall risk, and to remind them to implement the required fall prevention interventions. The DON stated that without the star indicators, staff might not remember or know to implement fall precautions, placing the resident at risk for falls. During a review of the facility's P&P titled Falling Star Program, dated 1/2025, the P&P indicated any resident with a fall while admitted to the facility would be included in the Falling Star Program and was to have star indicators on their door nameplate and wheelchair, if applicable. The P&P indicated there should be two star-shaped indicators if the resident had sustained a fall in the facility. 5. During a review of Resident 2's Admission Record, the Admission Record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's admitting diagnoses included abnormalities of gait (pattern of walking) and mobility, generalized muscle weakness, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) with dyskinesia (involuntary, repetitive, and abnormal movements). During a review of Resident 2's H&P, dated 11/26/2024, the H&P indicated Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had moderately impaired cognition (a decline in thinking and memory that makes it hard to complete complex tasks). The MDS indicated Resident 2 required substantial to maximal assistance from staff to get dressed and maintain personal hygiene after voiding or having a bowel movement. The MDS indicated Resident 2 required partial to moderate assistance from staff for mobility while in bed, to get out of bed, and when transitioning from bed to wheelchair, or wheelchair to bed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2's care plan titled Falling Star Program ., dated 12/21/2024, the care plan indicated Resident 2 was to have two yellow star-shaped indicators on her wheelchair and outside of her room by her nameplate. During a review of Resident 2's COC assessment, dated 12/25/2024, the assessment indicated on 12/25/2024 Resident 2 had an unwitnessed fall. The COC indicated staff found Resident 2 lying on her back on the floor near the foot of her roommate's bed. The assessment indicated Resident 2 had an abrasion (scrape or superficial injury) on her left arm and complained of a 3 out of 10 pain. During an observation on 2/25/2025 at 1:52 PM, outside of Resident 2's room, the nameplate outside of Resident 2's room did not have star-shaped indicators next to Resident 2's name. During a concurrent observation and interview, on 2/26/2025 at 1:20 PM, with LVN 2, Resident 2's wheelchair was parked outside of Resident 2's room in the hallway. LVN 2 stated the wheelchair had Resident 2's room and bed indicated on the back of the seat, but did not have any star-shaped indicators attached to it. During a concurrent interview and record review on 2/27/2025 at 1:14 PM, with the DON, Resident 2's COC assessment, dated 12/25/2024, and care plan titled Falling Star Program ., dated 12/21/2024, were reviewed. The DON stated the COC assessment indicated on 12/25/2024 Resident 2 had an unwitnessed fall but a Morse Fall Scale assessment was not done after the fall. The DON stated it was the facility's policy to conduct a fall assessment after any fall, to identify Resident 2's level of risk for falls. The DON stated the assessment would also prompt a review of Resident 2's fall risk care plans to identify if there was a need for new or revised fall prevention interventions. The DON stated a Morse Fall Scale assessment should have been done and failure to complete one placed Resident 2 at risk for repeat falls. The DON stated Resident 2's care plan indicated Resident 2 required star-shaped indicators on her wheelchair and on her nameplate outside of her room. The DON stated the failure to implement the star-shaped indicators placed Resident 2 at risk for falls. During a review of the facility's P&P titled Falling Star Program, dated 1/2025, the P&P indicated fall risk assessments were to be completed as needed. Based on observation, interview, and record review, the facility failed to maintain a safe and hazard free environment for two of three sampled residents (Resident 1 and Resident 2), when: 1. Licensed Vocational Nurse (LVN) 1 left Resident 1 unattended and unsupervised at Nurse's Station 3, on 2/14/2025. 2. Activity Staff (AS) 3 left Resident 1 at Nurse's Station 3, without verifying there was a charge nurse present to supervise Resident 1, on 2/14/2025. 3. On 2/25/2025, Resident 1 did not have bilateral fall mats (a cushioned floor pad designed to help prevent injury should a person fall) at her bedside, as ordered by the physician. 4. On 2/25/2025, Resident 1 did not have fall risk indicators outside of her room, or on her Geri-chair (a large, padded chair with a wheeled base, designed to assist individuals with limited mobility), in accordance with Resident 1's care plan. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	5. A Morse Fall Scale assessment (a clinical assessment tool used to predict a patient's risk of falling) was not conducted following Resident 2's fall on 12/25/2024. 6. On 2/26/2025, Resident 2 did not have fall risk indicators outside of her room, or on her wheelchair, in accordance with Resident 2's care plan. These deficient practices resulted in Resident 1 falling on 2/14/2025 and sustaining a displaced subcapital left femoral neck fracture (a broken bone in the upper part of the left thigh bone, where the broken pieces are significantly displaced from their normal position) requiring surgical intervention in a general acute care hospital (GACH). These deficient practices also placed Resident 1 and Resident 2 at risk for further falls and fall related injuries. Findings: 1. During a review of Resident 1's Admission Record, the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] and was most recently readmitted to the facility on [DATE]. Resident 1's admitting diagnoses, as of 2/18/2025, included generalized muscle weakness, left thigh bone fracture, history of falling, dementia (a progressive state of decline in mental abilities), epilepsy (a chronic brain disorder characterized by recurrent seizures, which are brief episodes of abnormal brain activity that can cause involuntary movements, loss of consciousness, or other symptoms), and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 1's History and Physical (H&P), dated 1/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P did not indicate diagnoses of osteoporosis or osteopenia (a condition characterized by low bone mineral density, which makes bones weaker and more prone to fractures). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/13/2025, the MDS, indicated Resident 1 had memory problems and severely impaired cognition (a significant decline in cognitive abilities that interferes with daily life and independence). The MDS indicated Resident 1 had impairments to her lower extremities (hip, knee, ankle, and foot) on both sides of her body. The MDS indicated Resident 1 was dependent on staff for all activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) and mobility while in and out of bed. The MDS indicated diagnoses of lack of coordination and generalized muscle weakness. During a review of Resident 1's care plan titled At risk for fall, dated 1/10/2025, the care plan indicated staff were to provide frequent visual monitoring of Resident 1 to reduce the risk of falls and/or injury. During a review of Resident 1's Morse Fall Scale Assessment, dated 1/11/2025, the assessment indicated Resident 1 was at high risk for falls due to impaired gait (an abnormal walking pattern), and overestimation (judging something too highly), and/or forgetfulness of her ability to walk safely. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Change of Condition (COC) assessment, dated 2/14/2025 at 3:10 PM, the COC indicated on 2/14/2025 Resident 1 had a witnessed fall, in the hallway. The COC indicated Resident 1 reported a 4 out of 10 pain (0: no pain, 1 to 3: mild pain, 4 to 6: moderate pain, and 7 to 10: severe pain) to her left hip. The COC indicated Resident 1 was administered Tylenol 650 milligrams (mg, a unit of dose measurement) for pain. The COC indicated Resident 1's physician was notified of the fall and the physician ordered for an immediate x-ray (a procedure that uses radiation to create images of the inside of the body) to rule out broken bones. During a review of the facility record titled Investigation Statement, dated 2/14/2025 at 3:10 PM, the record indicated a handwritten statement by Licensed Vocational Nurse (LVN) 1 regarding Resident 1's fall on 2/14/2025. The record indicated on 2/14/2025 (no time specified), Resident 1 was sitting in a wheelchair near the nurse's station. The record indicated LVN 1 was assisting another resident in the hallway when Resident 1 fell . During a review of Resident 1's COC assessment, dated 2/14/2025 at 9:45 PM, the COC indicated the x-ray revealed Resident 1 had an acute (severe and sudden in onset) left thigh bone fracture related to a witnessed fall. The COC indicated Resident got up unassisted and lost her balance . The COC indicated Resident 1 reported an 8 out of 10 pain. The COC indicated staff administered Norco 5/325 mg (a combination medication used to relieve severe pain when other pain medication was insufficient) for pain. The COC indicated Resident 1's physician gave an order for the resident to be a transferred to a GACH for evaluation and treatment of the left thigh bone fracture. During a review of Resident 1's progress note, dated 2/14/2025 at 11:45 PM, the progress note indicated Resident 1 was transferred to the GACH on 2/14/2025 at 11:30 PM. During a review of Resident 1's GACH record titled History and Physical, dated 2/15/2025 (untimed), the record indicated Resident 1 was brought to the GACH after falling onto her left side while trying to walk. The record indicated a plan to admit Resident 1 to the medical-surgical unit (a unit for patients recovering from surgery, preparing for surgery, or managing various medical conditions). During a review of Resident 1's GACH record titled Radiology Report, dated 2/15/2025 at 2:23 AM, the record indicated an x-ray was taken of Resident 1's left hip. The record indicated Resident 1 had a displaced subcapital left femoral neck fracture. During a review of Resident 1's facility progress note, dated 2/15/2025 at 1:42 PM, the progress note indicated Resident 1 was admitted to the GACH and in the process of being referred to, and evaluated by, an orthopedic physician (a physician who treats injuries and diseases involving muscles, bones, joints, ligaments, and tendons) for a possible left hip hemiarthroplasty (surgical replacement of half of the hip joint) related to her fracture. During a review of Resident 1's GACH record titled Discharge Summary Notes, dated 2/17/2025 at 8:07 AM, the record indicated a final diagnosis of acute left femoral neck fracture. The record indicated Resident 1's conservator (a person appointed by a court to manage her care) declined to provide consent for orthopedic surgery (a surgical procedure on the musculoskeletal system), and Resident 1 was to be discharged back to the facility. During a review of Resident 1's facility progress note, dated 2/18/2025 at 11:45 AM, the progress note indicated Resident 1 was readmitted to the facility on [DATE]. (continued on next page)

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 02/27/2025
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's medical record titled Routine Pain Assessment Flowsheet , undated, and Pain Assessment Flowsheet, undated, the records indicated Resident 1 received Norco 5/325 mg for the following pain levels: On 2/20/2025 at 3:00 AM: 7/10 pain to her left lower extremity (leg). On 2/20/2025 at 9:00 AM: 8/10 pain to her left lower extremity. On 2/21/2025 at 5:00 AM: 7/10 pain to her left lower extremity. On 2/21/2025 at 11:30 AM: 7/10 pain to her left lower extremity. On 2/22/2025 at 9:00 AM: 8/10 pain to her left lower extremity. On 2/22/2025 at 2:00 PM: 8/10 pain to her left lower extremity. On 2/24/2025 at 9:00 AM: 8/10 pain to her left lower extremity. On 2/25/2025 at 9:00 AM: 7/10 pain to her left lower extremity. On 2/27/2025 at 9:00 AM: 8/10 pain to her left lower extremity. On 2/27/2025 at 2:30 PM: 7/10 pain to her left lower extremity. During a telephone interview on 2/26/2025 at 9:14 AM, with LVN 1, LVN 1 stated she was Resident 1's Charge Nurse the afternoon of 2/14/2025, and was aware Resident 1 was at risk for falls. LVN 1 stated she was supervising Resident 1 at the nurse's station and there were no other staff present when Resident 1 fell . LVN 1 stated she did not ask any staff member to supervise Resident 1 before leaving the resident unattended at the nurse's station. LVN 1 stated she was down the hall from Resident 1, with her back towards the resident, when she heard Resident 1's wheelchair alarm. LVN 1 stated she turned around and saw Resident 1 standing up and holding onto the armrest of her wheelchair for support. LVN 1 stated she was too far away from Resident 1 to intervene, and she observed Resident 1 fall to the ground onto her left side. LVN 1 stated Resident 1 denied any pain during the shift, prior to the fall, but complained of pain to her left hip after the fall. LVN 1 stated she should not have left Resident 1 unattended and unsupervised at the nurse's station. LVN 1 stated the fall could have been prevented if Resident 1 was not left unsupervised. During a telephone interview on 2/26/2025 at 4:43 PM, with Registered Nurse (RN) 1, RN 1 stated Resident 1's care plan intervention of frequent visual monitoring meant Resident 1 should not be left unattended. RN 1 stated to implement this intervention, Resident 1 should always be within a supervising staff member's line of sight. RN 1 stated leaving a resident who required frequent visual monitoring unattended could result in a fall and injury. (continued on next page)

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 02/27/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review, on 2/27/2025 at 1:02 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled Safety and Supervision of Residents, revised 1/2025, was reviewed. The DON stated the P&P indicated resident supervision was a core component for resident safety. The DON stated LVN 1 should not have left Resident 1 unattended because Resident 1 was known as a high risk for falls. The DON stated LVN 1 should have ensured another staff was supervising Resident 1, before leaving the resident at the nurse's station. 2. During a review of the facility record titled Investigation Statement, dated 2/18/2025, untimed, the record indicated a handwritten statement by Activity Staff (AS) 1 regarding Resident 1's fall on 2/14/2025. The record indicated on 2/14/2025 (time unspecified) Resident 1 was in the dining room requesting to be taken back to her room. The record indicated an unidentified staff wheeled Resident 1 to an unspecified nurse's station. During a concurrent interview and record review, on 2/25/2025 at 1:03 PM, with AS 1, the facility record titled Investigation Statement, dated 2/18/2025 (time unspecified), was reviewed. AS 1 stated the staff member who took Resident 1 to the nurse's station was identified as AS [TRUNCATED]