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	05/20/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and interview review, the facility failed to ensure infection prevention and control practices were implemented, by failing to: Ensure Resident 9's indwelling urinary catheter (catheter that drains urine from bladder into a bag outside the body) drainage bag was not dragging the floor. Ensure the Treatment Nurse used a disposable cloth (paper towel) to establish a clean field (table) before placing Resident 5's wound care supplies on the bedside table, as indicated in its policy and procedure (P&P) titled Wound Care. The facility had a system in place in the management and care of a resident's pet (dog) within the facility. Ensure linen barrels (bin) containing used protective personal protective equipment (PPE-specialized clothing/equipment worn by healthcare staff to protect themselves, residents and others from exposure to infectious agents and the transmission of disease) in two of four residents' rooms (Residents 6 and 7) who were on Enhanced Barrier Precautions (EBP, infection control measures using gowns and gloves during high-contact care to prevent the spread of multidrug-resistant organisms [MDROs]), were not overflowing and not left open/ exposed. These failures violated infection prevention and control practices and had the potential for cross-contamination of organisms, placing other residents, staffs and visitors at risk for infections.Findings: 1). During an observation on 5/20/2026 at 9:05 a.m., Resident 9 was observed up on a wheelchair propelling himself out of the room. Resident 9's catheter drainage bag was attached to the wheelchair and was dragging on the floor. During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 9's diagnoses included urinary tract infection (UTI- an infection in the bladder/urinary tract) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 9's care plan titled Alteration in urinary elimination secondary to use of indwelling foley catheter, dated 11/17/2024, the interventions indicated to do foley catheter care every shift and monitor indwelling catheter. During a review of Resident 9's H&P dated 1/7/2026, the H&P indicated Resident 9 did not have the capacity to understand and make decisions. During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had severe cognition was severe cognitive impairment. Resident 9 was dependent with staff in putting on footwear, toileting, showering, and lower body dressing. During interview with the DON on 5/20/2026 at 12:00 p.m. the DON stated the catheter bag should not be touching the floor and that would pose an infection control risk to the resident. During a review of the facility's P& P titled Catheter Care, Urinary, dated 1/2026, the P&P indicated, to prevent catheter-associated urinary tract infections, be sure the catheter tubing and drainage bag are kept off the floor. 2). During an observation on 5/20/2026 at 10:30 a.m., the Licensed Vocational Nurse (LVN) 1 was observed placing wound care supplies (4x4 gauze [dressing], tape, scissors, a thick pad dressing and a cling wrap) on Resident 5's overbed table, for Resident 5's right great toe wound care. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including gangrene (death of body tissue caused by lack of blood supply) of the toe, Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic ulcer of the right foot. During a review of Resident 5's H &P dated 12/7/2025, the (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H &P indicated Resident 5 did not have the capacity to understand or make decisions. During a review of Resident 5's Minimum Data set the (MDS- a resident assessment tool) dated 3/6/2026, the MDS indicated Resident 5 had moderate cognitive impairment. The MDS indicated Resident 5 was dependent on staff for personal hygiene, lower body dressing and bathing. During review of Resident 5's physician orders dated 4/29/2026, the physician orders indicated cleanse right great toe with normal saline, pat dry paint with betadine solution apply abdominal pad wrap with roll gauze secure with tape every shift. During a review of Resident 5's care plan titled Resident has gangrene vascular ulcer on the right great toe, revised 5/13/2026, the goal indicated the resident will not have signs and symptoms of infection. The interventions indicated to monitor, document, report signs and symptoms of infections and treatment as ordered. During an interview on 5/20/2026 at 12:30 p.m. with the DON, the DON stated using a barrier (lining) to establish a clean field during wound care was a facility policy. Not following facility's policy placed the resident at risk for infections and violates infection control. During a review of the facility's P&P titled wound Care, dated 1/2026, the P&P indicated, the facility will use disposable cloth (paper towel is adequate) to establish a clean field to resident's overbed table. Place all items to be used during procedure on the clean field. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 3). During observation on 5/20/2026 at 10:24 a.m., a dog was observed tethered (tied with a rope) on an outside patio accessible to residents. The dog was lying on a white blanket and a soiled blue blanket with several wheelchair pads on the ground. The wheelchair was soiled and dog feces were observed in the patio area. During an interview on 5/20/2026 2:45 p.m., with the Administrator, the Administrator stated the dog belonged to Resident 8. The Administrator stated the facility did not have a P&P related to having animal (pet) on the premises. The Administrator stated the patio area should be cleaned by maintenance to prevent any infection control concerns. 4). During an observation on 5/20/2026 at 10:47 a.m., of Resident 6's room, the door had a signage indicating Enhanced Barrier Precautions. of Resident 6's room, the door had a signage indicating Enhanced Barrier Precautions. A linen barrel inside the resident's room was observed with soiled (dirty) PPEs that were overflowing, with lid open, exposing the used PPEs. During a review of Resident 6's admission Record, the admission Record indicated Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 6's diagnoses included stage 4 (full thickness skin loss with extensive destruction; tissue necrosis; or damage to muscle, bones) pressure ulcer to right shoulder and sacral area, gastrostomy tube (GT, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 6's care plan titled Enhanced Barrier Precautions due to the presence of GT and Stage 3 P.I. (pressure injury). At risk of acquiring or being a source of MDRO, initiated 4/23/2025, the goal indicated preventing the spread of microorganism among residents, visitors and staff. One of the interventions indicated to render enhanced precaution procedures as a precautionary measure in accordance with the facility's infection control plan, consistent with the requirement of the local health department. During a review of Resident 6's History and Physical (H&P) dated 10/10/2025, the H&P indicated Resident 6 did not have the capacity to understand or make decisions. During a review of Resident 6's, MDS, dated [DATE], the MDS indicated Resident 6 had severe cognitive (thinking process) impairment. Resident 6 was dependent upon the assistance of staff for all activities of daily living (dressing, bathing, toileting, and hygiene). 5). During an observation 5/20/2026 at 11:05 a.m., of Resident 7's room, the door had a signage indicating Enhanced barrier precaution. A linen barrel inside the resident's room was observed with soiled PPEs that were overflowing, with lid open, exposing the used PPEs. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including sacral stage 3 pressure (deep and painful wounds in the skin), local infection of the skin and subcutaneous tissue and chronic ulcer of the right lower leg (a slow healing leg wound). During a review of Resident 7's care plan titled Enhanced barrier precautions due to chronic wounds. At risk for acquiring or being a source of MDRO, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initiated 2/14/2026, the goal indicated to prevent the spread of microorganism among residents, visitors and staff. One of the interventions indicated to render enhanced precaution procedures as a precautionary measure in accordance with the facility's infection control plan, consistent with the requirement of the local health department. During a review of Resident 7's H&P dated 4/13/2026, the H &P indicated Resident 7 had the capacity to understand and make decisions. During a concurrent interview and record review on 5/20/2026 at 11:30 a.m. with the Director of Nursing (DON), the facility's P&P titled, Handling, Sorting and Disposal of Soiled Linen and Resident Personal Clothing, dated 1/2026 was reviewed. The P & P indicated cart must always be kept closed when not in use.