

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Riverbank Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2649 Topeka Street Riverbank, CA 95367	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137</p> <p>Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 1), was free from verbal abuse when his roommate Resident 2, verbally assaulted him with a racial epithet on multiple occasions.</p> <p>This failure resulted in Resident 1 being a victim of continued racially based verbal abuse.</p> <p>Findings:</p> <p>During an interview on 6/20/24, at 3 PM, with Resident 1, Resident 1 stated his roommate (Resident 2) was continuously cussing at me and using vulgar language. Resident 1 stated he had recently informed the facility's Social Services Department of this, and they told him Resident 2 would be moved to a different room on 6/17/24. Resident 1 stated that his roommate had yet not been moved as of 6/20/24 and was given no explanation why.</p> <p>During an interview on 6/21/24, at 4 PM, with Resident 1, Resident 1 stated Resident 2 had still not been moved out to a different room. Resident 1 stated nobody had come to him to address the situation despite his complaints. Resident 1 stated Resident 2 calls him [n-word]. Resident 1 stated that for one example, when Resident 2 turned his music on at 4 AM, he asked Resident 2 to turn it down and Resident 2 responded by saying, Shut up, [n-word]. Resident 1 stated, That's not OK. I pay money to be here, I should not be spoken to like that.</p> <p>During a concurrent observation and interview on 6/28/24, at 11:40 AM, with Resident 1, his room was observed. The room was noted to be under isolation precautions due to CRAB [Carbapenem-resistant Acinetobacter baumannii, an infectious disease that requires special isolation precautions]. There were 3 residents in the room: Resident 1, Resident 2, and Resident 3. Resident 1 stated Resident 2 verbally insults him with a racial epithet almost every day and Resident 2 only insults him, never Resident 3. Resident 2 was observed to be sleeping in his bed. Resident 3's bed was between Residents 1 and 2.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a comprehensive, standardized assessment tool) dated, 6/7/24, the MDS indicated at question C500 - Brief Interview for Mental Status a score of 15 out of a possible 15, which indicated Resident 1 was cognitively intact.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/28/24, at 11:43 AM, with Resident 3, Resident 3 stated, I've seen [Resident 2] call [Resident 1] the n-word all the time. He spits all the time, he cusses at [Resident 1] constantly.</p> <p>During a review of Resident 3's MDS dated , 4/5/24, the MDS indicated at question C500 - Brief Interview for Mental Status a score of 15 out of a possible 15, which indicated Resident 3 was cognitively intact.</p> <p>During an interview with Certified Nursing Assistant (CNA) 1, on 6/28/24, at 11:45 AM, CNA 1 stated she was caring for Resident 1, Resident 2, and Resident 3. CNA 1 stated Resident 2 can be super mean. He's awful with his roommate, he calls [Resident 1] the n-word, spits at him [but doesn't make contact]. I'm here three days a week, and he does this every day I'm here. I guarantee you it happens every day, even on the days I'm not here. A multitude of us CNAs got together and requested a room change. We told the charge nurse [Licensed Vocational Nurse 1, or LVN 1] about this a couple of weeks ago. We told the Social Services lady, the [Social Services Assistant, or SSA]. We said we know he has CRAB but there's an empty bed in [Room XX], and the other resident in there has CRAB also, so why don't we move [Resident 2] there? CNA 1 stated the resident in [Room XX] is of the same ethnicity as Resident 2, and by placing Resident 2 there, I don't think [Resident 2] will be doing that social thing.</p> <p>During an observation on 6/28/24, at 11:50 AM, [Room XX] was observed. Inside there were two beds, the A bed was unoccupied, the B bed was occupied by a male resident. [Room XX] was under CRAB isolation precautions.</p> <p>During a concurrent record review and interview on 6/28/24, at 12:15 PM, with the Social Services Director (SSD), Resident 1's Progress Notes (PN) were reviewed. There were no entries in the PN or elsewhere in Resident 1's clinical record regarding the allegations of verbal abuse made by Resident 1. The SSD stated her assistant, the SSA, was not on duty today. The SSD stated she is the SSA's supervisor, and the SSA reports to her. The SSD stated Resident 2 likes to spit at people, spitting in their direction, no contact. Other from that, he's pretty good, he's quiet. I've not gotten any complaints about him, just the spitting. I've not heard of any complaints about him using the n-word toward other residents. This is the first I've heard about it. Now that I know about it, we will do a room change immediately.</p> <p>During an interview on 6/28/24, at 12:30 PM, with the Administrator, the Administrator was informed of Resident 1's complaint of verbal abuse, and Resident 2 repeatedly calling him the n-word. The Administrator stated, I'm not aware of [Resident 2] using the n-word toward another resident. When asked if the Administrator considered this verbal abuse, the Administrator stated, That would be unwelcome language. We will work on a room change today. The Administrator stated the facility is licensed for 99 beds, and the current census is 93, and there was an available bed in [Room XX] that was also on CRAB precautions.</p> <p>During an interview on 6/28/24, at 2 PM, with the Director of Nursing (DON), the DON was informed of Resident 1's allegation of verbal abuse from Resident 2. The DON stated she was not aware of Resident 2 calling Resident 1 the ' n-word.' The DON stated, First I've heard of it. The DON stated LVN 1 is not on duty today.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/1/24, at 1:45 PM, with the DON, the DON stated Resident 2 had been moved to [Room XX] on 6/28/24, after the 2 PM interview on that day.</p> <p>During an interview on 7/1/24, at 2:45 PM, with the SSA, the SSA stated, We were told about [Resident 2] calling [Resident 1] the n-word on Monday, 6/24/24. It had happened on 6/22/24. [Resident 1] was really upset about it. That's when I got [the facility's Infection Prevention Nurse, or IPN] involved [due to the CRAB precautions]. The SSA stated the IPN was going to check and get approval for a room change and was told this room change was denied on 6/25/24. The SSA stated she considered the behavior from Resident 2 towards Resident 1 to be verbal abuse and stated, Yeah, that was verbal abuse, absolutely. We had a team meeting about it. We talked to our Administrator about it, of course. The SSA stated the SSD was aware, I had told her. The SSD stated this incident was not reported to the Department and, I think the priority was to get him moved out of that room. I heard he got moved [on 6/28/24].</p> <p>During an interview on 7/1/24, at 4:35 PM, with LVN 1, LVN 1 stated she works with Resident 1 and Resident 2 three days a week. LVN 1 stated Resident 1 and Resident 2 do not get along. [Resident 2] can become really angry sometimes. He yells at his roommate [Resident 1], makes racial comments. The things that are said are just inappropriate. [Resident 3] is in the middle, this involves him too. All the men in that room are non-ambulatory, and no one should have to listen to that. [Resident 2] is smart enough to stop whenever I enter the room. I spoke to SSA and brought it to their attention on 6/24/24. She was walking down the hallway to their morning meeting. They said they were aware. I assumed it was to be discussed in that meeting. I understand [Resident 2] has been moved, I think the delay was because both [Resident 2] and his new roommate have CRAB, that's what took so long.</p> <p>During a concurrent observation and interview on 7/10/24, at 1:10 PM, in Resident 1's room, with Resident 1, Resident 2 was noted to no longer residing in the room. Resident 1 stated, It's much better now, thank you.</p> <p>During an observation on 7/10/24, at 1:15 PM, Resident 2 was noted to be residing in [Room XX].</p> <p>During an interview on 7/16/24, at 2:20 PM, with the RN Consultant (RNC), the RNC stated, There was no altercation between [Resident 1 and Resident 2]. Both men are bed bound, and there was no altercation. We did a room change [for Resident 2] because [Resident 1] complained of [Resident 2]'s behavior. I don't remember what it was about, I'm not sure. The RNC stated she was in the facility when the room change was done on 6/28/24.</p> <p>During an interview with the Administrator, on 7/16/24, at 3:05 PM, the Administrator stated Resident 2 was moved to [Room XX] on 6/28/24. The Administrator stated the room change was done because Resident 1 and Resident 2 were not happy with each other. We knew [Resident 1] was unhappy with his roommate. I am uncertain why. I couldn't say what the disagreement was about. The Administrator was reminded that the HFEN personally told him on 6/28/24 (the date of the room change), that Resident 1 had stated Resident 2 called him the n-word on multiple occasions, and facility staff interviews had confirmed this. The Administrator stated the report of abuse from Resident 1 was not reported to the Department, and an investigation of the abuse was not done. The Administrator stated, We knew that they disagreed. We don't report disagreements.</p> <p>During a review of the facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program , dated 4/21, the P&P indicated, in part:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from verbal, mental, sexual or physical abuse. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:</p> <ol style="list-style-type: none"> 1. Protect residents from abuse. by anyone including, but not necessarily limited to: <ol style="list-style-type: none"> b. other residents 2. Develop and implement policies and protocols to prevent and identify: <ol style="list-style-type: none"> a. abuse or mistreatment of residents 7. Implement measures to address factors that may lead to abusive situations, for example: <ol style="list-style-type: none"> c. instruct staff regarding appropriate ways to address interpersonal conflicts; and d. help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment. 10. Protect residents from any further harm during investigations.

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137</p> <p>Based on interview and record review, the facility failed to investigate an allegation of verbal abuse for one of six sampled residents (Resident 1), when Resident 1 had complained to facility staff that his roommate, Resident 2, was continuously calling him a racial epithet.</p> <p>This failure resulted in Resident 1 being subjected to further verbal abuse from Resident 1. [Cross Reference F600].</p> <p>Findings:</p> <p>During an interview on 6/20/24, at 3 PM, with Resident 1, Resident 1 stated his roommate (Resident 2) was continuously cussing at me and using vulgar language. Resident 1 stated he had recently informed the facility's Social Services Department of this.</p> <p>During an interview on 6/21/24, at 4 PM, with Resident 1, Resident 1 stated Resident 2 calls him [n-word]. Resident 1 stated that for one example, when Resident 2 turned his music on at 4 AM, he asked Resident 2 to turn it down and Resident 2 responded by saying, Shut up, [n-word]. Resident 1 stated, That's not OK. I pay money to be here, I should not be spoken to like that.</p> <p>During a concurrent observation and interview on 6/28/24, at 11:40 AM, with Resident 1, his room was observed. There were 3 residents in the room: Resident 1, Resident 2, and Resident 3. Resident 1 stated Resident 2 verbally insults him with racial epithets almost every day and Resident 2 only insults him, never Resident 3. Resident 2 was observed to be sleeping. Resident 3's bed was between Residents 1 and 2.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a comprehensive, standardized assessment tool) dated, 6/7/24, the MDS indicated at question C500 - Brief Interview for Mental Status a score of 15 out of a possible 15, which indicated Resident 1 was cognitively intact.</p> <p>During an interview on 6/28/24, at 11:43 AM, with Resident 3, Resident 3 stated, I've seen [Resident 2] call [Resident 1] the n-word all the time. He spits all the time, he cusses at [Resident 1] constantly.</p> <p>During a review of Resident 3's MDS, dated , 4/5/24, the MDS indicated at question C500 - Brief Interview for Mental Status a score of 15 out of a possible 15, which indicated Resident 3 was cognitively intact.</p> <p>During an interview with Certified Nursing Assistant (CNA) 1, on 6/28/24, at 11:45 AM, CNA 1 stated she was caring for Resident 1, Resident 2, and Resident 3. CNA 1 stated Resident 2 is can be super mean. He's awful with his roommate, he calls [Resident 1] the n-word, spits at him [but doesn't make contact]. I'm here three days a week, and he does this every day I'm here. I guarantee you it happens every day, even on the days I'm not here. A multitude of us CNAs got together and requested a room change. We told the charge nurse [Licensed Vocational Nurse 1, or LVN 1] about this a couple of weeks ago. We told the Social Services lady, the [Social Services Assistant, or SSA].</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent record review and interview on 6/28/24, at 12:15 PM, with the Social Services Director (SSD), Resident 1's Progress Notes (PN) were reviewed. There were no entries in the PN or elsewhere in the clinical record regarding the allegations of verbal abuse made by Resident 1. The SSD stated her assistant, the SSA, was not in today. The SSD stated she is the SSA's supervisor, and the SSA reports to her. The SSD stated Resident 2 likes to spit at people, spitting in their direction, no contact. Other from that, he's pretty good, he's quiet. I've not gotten any complaints about him, just the spitting. I've not heard of any complaints about him using the n-word toward other residents. This is the first I've heard about it. Now that I know about it, we will do a room change immediately.</p> <p>During an interview on 6/28/24, at 12:30 PM, with the Administrator, the Administrator was informed of Resident 1's complaint of verbal abuse, and Resident 2 repeatedly calling him the n-word. The Administrator stated, I'm not aware of [Resident 2] using the n-word toward another resident. When asked if the Administrator considered this verbal abuse, the Administrator stated, That would be unwelcome language. We will work on a room change today. The Administrator stated the facility is licensed for 99 beds, and the current census is 93, and there was an available empty bed for a room change.</p> <p>During an interview on 6/28/24, at 2 PM, with the Director of Nursing (DON), the DON was informed of Resident 1's allegation of verbal abuse from Resident 2. The DON stated she was not aware of Resident 2 calling Resident 1 the n-word. The DON stated, First I've heard of it.</p> <p>During an interview on 7/1/24, at 1:45 PM, with the DON, the DON stated Resident 2 had been moved to [Room XX] on 6/28/24.</p> <p>During an interview on 7/1/24, at 2:45 PM, with the SSA, the SSA stated, We were told about [Resident 2] calling [Resident 1] the n-word on Monday, 6/24/24. It had happened on 6/22/24. [Resident 1] was really upset about it. The SSA stated she considered the behavior from Resident 2 towards Resident 1 to be verbal abuse and stated, Yeah, that was verbal abuse, absolutely. We had a team meeting about it. We talked to our Administrator about it, of course. The SSA stated the SSD was also aware, and stated, I had told her. The SSD stated this incident was not reported to the Department and, I think the priority was to get him moved out of that room. I heard he got moved [on 6/28/24].</p> <p>During an interview on 7/1/24, at 4:35 PM, with LVN 1, LVN 1 stated she works with Resident 1 and Resident 2 three days a week. LVN 1 stated Resident 1 and Resident 2 do not get along. [Resident 2] can become really angry sometimes. He yells at his roommate [Resident 1], makes racial comments. The things that are said are just inappropriate. [Resident 3] is in the middle, this involves him too. All the men in that room are non-ambulatory, and no one should have to listen to that. [Resident 2] is smart enough to stop whenever I enter the room. I spoke to SSA and brought it to their attention on 6/24/24. She was walking down the hallway to their morning meeting. They said they were aware. I assumed it was to be discussed in that meeting.</p> <p>During a concurrent observation and interview on 7/10/24, at 1:10 PM, in Resident 1's room, with Resident 1, Resident 2 was noted to no longer residing in the room. Resident 1 stated, It's much better now, thank you.</p> <p>During an observation on 7/10/24, at 1:15 PM, Resident 2 was noted to be residing in [Room XX].</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/16/24, at 2:20 PM, with the RN Consultant (RNC), the RNC stated, There was no altercation between [Resident 1 and Resident 2]. Both men are bed bound, and there was no altercation. We did a room change [for Resident 2] because [Resident 1] complained of [Resident 2]'s behavior. I don't remember what it was about, I'm not sure. The RNC stated she was in the facility when the room change was done on 6/28/24.</p> <p>During an interview with the Administrator, on 7/16/24, at 3:05 PM, the Administrator stated Resident 2 was moved to [Room XX] on 6/28/24. The Administrator stated the room change was done because Resident 1 and Resident 2 were not happy with each other. We knew [Resident 1] was unhappy with his roommate. I am uncertain why. I couldn't say what the disagreement was about. The Administrator was reminded that the HFEN personally told him on 6/28/24 (the date of the room change), that Resident 1 had stated Resident 2 called him the n-word on multiple occasions, and facility staff interviews had confirmed this. The Administrator stated, We knew that they disagreed. We don't report disagreements. The Administrator stated the report of abuse from Resident 1 was not reported to the Department, and an investigation of the abuse allegation was also not conducted.</p> <p>During a review of the facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program , dated 4/21, the P&P indicated, in part:</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from. verbal, mental, sexual or physical abuse. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:</p> <p>8. Identify and investigate all possible incidents of abuse, neglect, mistreatment.</p> <p>9. Investigate and report any allegations within timeframes required by federal requirements.</p> <p>10. Protect residents from any further harm during investigations.</p> <p>During a review of the facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/22, the P&P indicated, in part:</p> <p>Policy Statement - All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are. thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>Reporting Allegations to the Administrator and Authorities -</p> <p>6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.</p> <p>Investigating Allegations -</p> <p>1. All allegations are thoroughly investigated. The administrator initiates investigations.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137</p> <p>Based on interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Report an allegation of verbal abuse to the California Department of Public Health for one of six sampled residents (Resident 1) when Resident 2 called him a racial epithet on multiple occasions, and 2. The facility did not report the results of the abuse investigation to the California Department of Public Health within five days. <p>These failures resulted in the verbal abuse of Resident 1 to go uninvestigated, subjecting Resident 1 to continued verbal abuse.</p> <p>Findings:</p> <p>During an interview on 6/20/24, at 3 PM, with Resident 1, Resident 1 stated his roommate (Resident 2) was continuously cussing at me and using vulgar language. Resident 1 stated he had recently informed the facility's Social Services Department of this.</p> <p>During an interview on 6/21/24, at 4 PM, with Resident 1, Resident 1 stated Resident 2 calls him [n-word]. Resident 1 stated that for one example, when Resident 2 turned his music on at 4 AM, he asked Resident 2 to turn it down and Resident 2 responded by saying, Shut up, [n-word]. Resident 1 stated, That's not OK. I pay money to be here, I should not be spoken to like that.</p> <p>During a concurrent observation and interview on 6/28/24, at 11:40 AM, with Resident 1, his room was observed. There were 3 residents in the room: Resident 1, Resident 2, and Resident 3. Resident 1 stated Resident 2 verbally insults him with racial epithets almost every day and Resident 2 only insults him, never Resident 3. Resident 2 was observed to be sleeping. Resident 3's bed was between Residents 1 and 2.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a comprehensive, standardized assessment tool) dated, 6/7/24, the MDS indicated at question C500 - Brief Interview for Mental Status a score of 15 out of a possible 15, which indicated Resident 1 was cognitively intact.</p> <p>During an interview on 6/28/24, at 11:43 AM, with Resident 3, Resident 3 stated, I've seen [Resident 2] call [Resident 1] the n-word all the time. He spits all the time, he cusses at [Resident 1] constantly.</p> <p>During a review of Resident 3's MDS dated, 4/5/24, the MDS indicated at question C500 - Brief Interview for Mental Status a score of 15 out of a possible 15, which indicated Resident 3 was cognitively intact.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Riverbank Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2649 Topeka Street Riverbank, CA 95367	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Certified Nursing Assistant (CNA) 1, on 6/28/24, at 11:45 AM, CNA 1 stated she was caring for Resident 1, Resident 2, and Resident 3. CNA 1 stated Resident 2 is can be super mean. He's awful with his roommate, he calls [Resident 1] the n-word, spits at him [but doesn't make contact]. I'm here three days a week, and he does this every day I'm here. I guarantee you it happens every day, even on the days I'm not here. A multitude of us CNAs got together and requested a room change. We told the charge nurse [Licensed Vocational Nurse 1, or LVN 1] about this a couple of weeks ago. We told the Social Services lady, the [Social Services Assistant, or SSA].</p> <p>During a concurrent record review and interview on 6/28/24, at 12:15 PM, with the Social Services Director (SSD), Resident 1's Progress Notes (PN) were reviewed. There were no entries in the PN or elsewhere in the clinical record regarding the allegations of verbal abuse made by Resident 1. The SSD stated her assistant, the SSA, was not in today. The SSD stated she is the SSA's supervisor, and the SSA reports to her. The SSD stated Resident 2 likes to spit at people, spitting in their direction, no contact. Other from that, he's pretty good, he's quiet. I've not gotten any complaints about him, just the spitting. I've not heard of any complaints about him using the n-word toward other residents. This is the first I've heard about it. Now that I know about it, we will do a room change immediately.</p> <p>During an interview on 6/28/24, at 12:30 PM, with the Administrator, the Administrator was informed of Resident 1's complaint of verbal abuse, and Resident 2 repeatedly calling him the n-word. The Administrator stated, I'm not aware of [Resident 2] using the n-word toward another resident. When asked if the Administrator considered this verbal abuse, the Administrator stated, That would be unwelcome language. We will work on a room change today. The Administrator stated the facility is licensed for 99 beds, and the current census is 93, and there was an available empty bed for a room change.</p> <p>During an interview on 6/28/24, at 2 PM, with the Director of Nursing (DON), the DON was informed of Resident 1's allegation of verbal abuse from Resident 2. The DON stated she was not aware of Resident 2 calling Resident 1 the ' n-word'. The DON stated, First I've heard of it.</p> <p>During an interview on 7/1/24, at 1:45 PM, with the DON, the DON stated Resident 2 had been moved to [Room XX] on 6/28/24.</p> <p>During an interview on 7/1/24, at 2:45 PM, with the SSA, the SSA stated, We were told about [Resident 2] calling [Resident 1] the n-word on Monday, 6/24/24. It had happened on 6/22/24. [Resident 1] was really upset about it. The SSA stated she considered the behavior from Resident 2 towards Resident 1 to be verbal abuse and stated, Yeah, that was verbal abuse, absolutely. We had a team meeting about it. We talked to our Administrator about it, of course. The SSA stated the SSD was aware, and stated, I had told her. The SSD stated this incident was not reported to the Department and, I think the priority was to get him moved out of that room. I heard he got moved [on 6/28/24].</p> <p>During an interview on 7/1/24, at 4:35 PM, with LVN 1, LVN 1 stated she works with Resident 1 and Resident 2 three days a week. LVN 1 stated Resident 1 and Resident 2 do not get along. [Resident 2] can become really angry sometimes. He yells at his roommate [Resident 1], makes racial comments. The things that are said are just inappropriate. [Resident 3] is in the middle, this involves him too. All the men in that room are non-ambulatory, and no one should have to listen to that. [Resident 2] is smart enough to stop whenever I enter the room. I spoke to SSA and brought it to their attention on 6/24/24. She was walking down the hallway to their morning meeting. They said they were aware. I assumed it was to be discussed in that meeting.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 7/10/24, at 1:10 PM, in Resident 1's room, with Resident 1, Resident 2 was noted to no longer be in the room. Resident 1 stated, It's much better now, thank you.</p> <p>During an observation on 7/10/24, at 1:15 PM, Resident 2 was noted to be residing in [Room XX].</p> <p>During an interview on 7/16/24, at 2:20 PM, with the RN Consultant (RNC), the RNC stated, There was no altercation between [Resident 1 and Resident 2]. Both men are bed bound, and there was no altercation. We did a room change [for Resident 2] because [Resident 1] complained of [Resident 2]'s behavior. I don't remember what it was about, I'm not sure. The RNC stated she was in the facility when the room change was done on 6/28/24.</p> <p>During an interview with the Administrator, on 7/16/24, at 3:05 PM, the Administrator stated Resident 2 was moved to [Room XX] on 6/28/24. The Administrator stated the room change was done because Resident 1 and Resident 2 were not happy with each other. We knew [Resident 1] was unhappy with his roommate. I am uncertain why. I couldn't say what the disagreement was about. The Administrator was reminded that the HFEN personally told him on 6/28/24, the date of the room change, that Resident 1 had stated Resident 2 called him the 'n-word' on multiple occasions, and facility staff interviews had confirmed this. The Administrator stated, We knew that they disagreed. We don't report disagreements. The Administrator stated the report of abuse from Resident 1 was not reported to the Department, and an investigation of the abuse allegation was also not conducted.</p> <p>During a review of the facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program , dated 4/21, the P&P indicated, in part:</p> <p>Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from. verbal, mental, sexual or physical abuse. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:</p> <ol style="list-style-type: none"> 1. Protect residents from abuse. by anyone including, but not necessarily limited to: <ol style="list-style-type: none"> b. other residents 2. Develop and implement policies and protocols to prevent and identify: <ol style="list-style-type: none"> a. abuse or mistreatment of residents 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment. 9. Investigate and report any allegations within timeframes required by federal requirements. 10. Protect residents from any further harm during investigations. <p>During a review of the facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/22, the P&P indicated, in part:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Policy Statement - All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <p>Reporting Allegations to the Administrator and Authorities -</p> <p>1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.</p> <p>2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies:</p> <p>a. The state licensing/certification agency responsible for surveying/licensing the facility;</p> <p>b. The local/state ombudsman;</p> <p>c. The resident's representative;</p> <p>e. Law enforcement officials;</p> <p>f. The resident's attending physician; and</p> <p>g. The facility medical director.</p> <p>3.Immediately is defined as:</p> <p>a. within two hours of an allegation involving abuse or result in serious bodily injury; or</p> <p>b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.</p> <p>Follow-Up Report -</p> <p>1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report.</p>		