STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055213	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rialto Post Acute Center	1471 S Riverside Ave Rialto, CA 92376

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report two of three sampled residents (Resident 1 and Resident 2) per their policy and procedure to the California Department of Public Health (CDPH) of alleged abuse, when a staff member allegedly twisted Resident 1's wrist and when a Certified Nurse Assistant (CNA) allegedly pushed Resident 2's leg forcibly while on a mechanical lift resulting in pain . This failure has potential to affected (Resident 1 and Resident 2)'s health, safety, and well-being. Findings: During review of Residents 1's admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis after cerebrovascular disease affecting left side (paralysis and weakness on one side of the body after stroke), hypertensive heart disease with heart failure (heart conditions caused by high blood pressure that leads to the heart's inability to pump enough blood), chronic obstructive pulmonary disease (lung disease that block airflow and make it difficult to breath), depression (a condition of feeling of sadness). During an interview on March 11, 2025, at 10:15 AM, with Resident 1 (Resident 1). Resident 1 stated that Licensed Vocational Nurse 1 (LVN 1) twisted her right wrist while trying to grab her phone to turn it off. Resident 1 stated that her phone was somehow got connected to the facility's overhead speaker. Resident 1 stated she made Charge Nurse (CN 1) aware of the incident and was complaining of a burning sensation on right wrist. During a phone interview on March 11, 2025, at 11:20 AM, with LVN 1, the LVN 1 stated that he was only trying to get Resident's 1 phone to turn it off. LVN 1 stated I did not twist her right wrist; I did not even touch her. I was only trying to help her turn off the phone and she started screaming and crying . LVN1 stated that Administrator (ADM) and Director of Nursing (DON) was notified. During a phone interview on March 11, 2025, at 12:20 PM with Charge Nurse1 (CN1), the CN1 stated she heard voices from the overhead speaker and went to the resident's room to check what was happening. She met with the Registered Nurse 1 (RN 1) in the room. Resident 1 stated that LVN 1 twisted her right wrist. CN1 stated they reported the incident to the Administrator (ADM). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of Resident 2's admission Record, the documents indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (lung disease that block airflow and make it difficult to breath) , peptic ulcer (open sore in the lining of the stomach), esophagitis (inflammation that damages the tube running from the throat to the stomach), type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar). During an interview on March 11, 2025, at 10:35 AM with Resident 2 (Resident 2). Resident 2 stated on March 8,2025, her Certified Nurse Assistant (CNA1) pushed her left leg forcibly while using the Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility). Resident 2 stated My left leg has been hurting and requiring pain medications around the clock and I have been in bed . During a phone interview on March 11,2025, at 12:45 PM, Certified Nursing Assistant (CNA) stated I lightly touched Resident 2's leg to repositioned it. I did not use any force. I took my hands off when she stated that it was hurting her . During a phone interview on March 14,2025, at 3:20 PM. LVN 2 stated I was passing medications and Resident 2 stated that she was in pain due to the incident that happened yesterday, March 8, 2025, when a CNA moved her leg with force while using the Hoyer lift with transferring . During an interview with Director of Nursing (DON) on March 11,2025, at 1:30 PM, when DON asked if DON reported the alleged abuse on Resident 1 and Resident 2, DON stated they did not report it. When asked if she should have reported the incident according to the facility's policy, she stated that she came from Los Angeles County and not familiar with the policy of San [NAME] County. During an interview on March 11, 2025, at 1:45, PM, with ADM, when asked if the facility reported the alleged abuse on Resident 1 and Resident 2, the ADM stated, We did not report it because when we interviewed LVN1 about the incident, he stated that he did not touch Resident 1, and Resident 1 has a behavior of false accusations in the past. Regarding, Resident 2's allegation, ADM stated she did not know about the alleged abuse made by Resident 2. When ADM asked if it should have been reported, she stated that she will report both allegations of abuse to Law enforcement agencies, ombudsman and California Department of Public Health (CDPH). ADM also stated she will suspend LVN1 and CNA1 pending investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review with the Admin on March 11, 2025, at 1:45, PM, the facility's policy titled, Abuse Investigation and Reporting revised July 2017, was reviewed. The policy indicated 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local /State Ombudsman; c. The Resident's representative; d. Adult Protective Services; e. Law enforcement officials; f. The attending physicians and g. the facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violations involve abuse or has resulted in serious bodily injury or twenty -four (24) hours if the alleged violation does not involved abuse and not resulted in serious bodily injury. The ADM acknowledged that they did not report the alleged abuse with Resident 1 and Resident 2 to CDPH and other appropriate agencies and therefore did not follow the facility policy.