| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055213 | A. Building<br>B. Wing | 05/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rialto Post Acute Center | 1471 S Riverside Ave<br>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 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110<br><br>Based on interview and record review, the facility failed to uphold the dignity of one of three residents (Resident 1) when two Certified Nursing Assistants (CNAs) were observed by a surveyor exposing resident 1 ' s body while assisting with transferring Resident 1 in bed.<br><br>This failure has the potential to expose clinically compromise Resident 1 to the public when they pass by the room.<br><br>Findings:<br><br>During a review of Resident 1's clinical record, the face sheet (contains demographic and medical information), indicated Resident 1 was admitted on [DATE], with diagnoses that included Alzheimer ' s dementia (a general term for a decline in memory and other cognitive abilities that interfere with daily life).<br><br>During observation on April 30, 2025, at 12:23 PM in Resident 1 ' room, the surveyor noted that two CNAs (CNA 1 and CNA 2) were assisting Resident 1 whose abdomen and diaper were exposed, as the curtain for privacy was not drawn and the door was left wide open.<br><br>During an interview on April 30, 2025, at 12:26 PM with CNA 1 and CNA 2, CNA 1 expressed that it is inappropriate to lift Resident 1 while Resident 1 brief and abdomen are visible. She indicated that the curtain should have been drawn. Additionally, she emphasized that exposing Resident 1 compromises his dignity. CNA 2 agreed with CNA 1's assessment.<br><br>During interview on April 30, 2025, at 2:10 PM with the Director of Nursing (DON 1), the DON 1 emphasized that CNA 1 and CNA 2 are failing to uphold resident privacy, which is a violation of established guidelines and is deemed unacceptable.<br><br>During a review of Facility Policy and Procedure (P&P) dated February 2020, titled, Quality of Life - dignity indicated, .1. Residents are treated with dignity and respect at all times . |

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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