

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER Rialto Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on observation, interview and record review, the facility failed to cross check discharge medications according to the facility policy for one of four residents (Resident 4), when a Licensed Vocational Nurse (LVN 1) improperly transferred Resident 4's Atorvastatin (a medication intended to lower cholesterol and prevent strokes, heart attacks, and chest pain), as well as Eliquis (a blood thinner that reduces blood clotting) to the caregiver of Resident 1 during discharge, despite Resident 1 not being prescribed these medications.</p> <p>This failure led to the loss of medications and increased the risk of a stroke for Resident 4, while also exposing Resident 1 to potential adverse effects from the medications, which could result in injury and harm.</p> <p>Findings:</p> <p>During a review of Resident 4's clinical record, the face sheet (contains demographic and medical information), indicated Resident 4 was admitted on [DATE], with diagnoses that included hypertensive heart disease with heart failure (the heart is failing to pump blood effectively, and this is due to long-term high blood pressure).</p> <p>During a review of the clinical record for Resident 4 ' s the Brief Interview for Mental Status (BIMS- screening tool to identify and monitor cognitive decline), dated March 12,2025, indicated, Resident 4 ' s score was a 13, which indicated Resident 4 had no mental impairment.</p> <p>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 Encephalopathy (a change in how your brain functions), Cirrhosis of Liver (a lot of scars on your liver making it hard for the liver to do its job).</p> <p>During a review of the clinical record for Resident 1 ' s the Brief Interview for Mental Status (BIMS- screening tool to identify and monitor cognitive decline), dated March 12,2025, indicated, Resident 1 ' s score was a 12, which indicated Resident 1 had moderate cognitive impairment (there are significant changes in thinking and memory that begin to interfere with daily life and independence).</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent telephone interview and record review on May 16, 2025, at 10:46 PM, with the LVN 1, the LVN 1 stated on the day of discharge, she inadvertently provided two medication carts belonging to Resident 4 to the caregiver of Resident 1, who had come to pick up Resident 1. She handed over two carts, one of which contained Atorvastatin, while she overlooked the other medication. She further stated that the Social Worker Director (SWD 1) later reported that the family indicated the second medication was Eliquis. She acknowledged her mistake and recognized that it was unacceptable. During a review of the medication records for Residents 1 and 4, she confirmed that Resident 1 is not prescribed Atorvastatin or Eliquis, whereas Resident 4 is.</p> <p>During a review of Resident 4 ' s Medical Administration Record (MAR) for May of 2025, it was noted that Atorvastatin Calcium oral tablet 40 mg (a unit of measurement of mass in the metric system) is prescribed to be taken as one tablet by mouth at bedtime to manage hyperlipidemia (a condition marked by elevated lipid levels in the bloodstream). Additionally, Eliquis oral tablet 2.5 mg (Apixaban) is to be administered as one tablet by mouth twice daily for the prophylaxis (intervention measure) of deep vein thrombosis (a condition characterized by the formation of a blood clot in a major vein, typically in the leg).</p> <p>During a review of Resident 1 ' s MAR for May 2025, it was noted that neither Atorvastatin nor Eliquis was included in the list of prescribed medications for Resident 1.</p> <p>During a telephone interview on May 16, 2025, at 11:14 PM with the SWD 1, the SWD 1 stated that the sister of Resident 1 reported that Resident 1 was sent home with medications that were prescribed to another resident, specifically Atorvastatin and Eliquis, which Resident 1 does not take. Upon receiving this information, she immediately notified the Director of Nursing (DON 1).</p> <p>During a telephone interview on May 16, 2025, at 11:21 PM with DON 1, DON 1 stated that resident 1 was discharged on Friday along with the medications of Resident 4, specifically Atorvastatin and Eliquis. She indicated that she had reached out to the family, who were under the impression that Resident 1 had been administered Eliquis during his stay at the facility, which led them to take Resident 1 to the hospital due to noticeable bruising on his skin. She assured the family that Resident 1 had never received the medications while in the facility, as it had not been prescribed. She emphasized that LVN 1 ' s failure to verify the medications is unacceptable.</p> <p>During a concurrent telephone interview and record review on May 16, 2025, at 1:48 PM, with DON 1, the facility Policy & Procedure (P&P) titled, Discharge Summary and Plan, dated December 2016 was reviewed. The P&P indicated, .3. As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented . DON 1 confirmed the accuracy of policy as outlined.</p>		