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	03/16/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify signs of developing pressure ulcer (a tissue damage that results in full thickness loss of skin) in a timely manner for one of three sampled residents (Resident 1). This failure had the potential for Resident 1's pressure ulcer to worsen due to not receiving the proper treatment that it needs.Findings: During a review of Resident 1's admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included, quadriplegia paralysis of the limbs), multiple sclerosis (a condition where the body's healthy cells are mistakenly attacked by the body's cells and organs), acute respiratory failure (a condition where the lungs cannot get enough oxygen into the blood) and lymphocytosis (a condition indicating the body's cells and organs are fighting an infection). A review of Resident 1's Medical Record, titled Change in Condition Evaluation, dated March 3, 2026, documented by the Wound Treatment Nurse (WTN), indicated, CNA (certified nursing assistant) approached me and reported a pressure injury on patient right hip upon observation notice that resident denied any pain at that time on right hip wound stage 3 3.7x3 x 0.3 90% (percent) granulation and 10% slough noted called MD (medical director) and explained resident skin condition and received new orders for xeroform (sterile, non-adhering, petrolatum-based gauze dressing designed to keep wounds moist, protected, and promote healing). During an interview on March 16, 2026, at 10:45 AM, with Certified Nursing Assistant (CNA 1), CNA 1 stated, We do daily skin checks when we give care and report any change of skin problem we see to our charge nurses. CNA 1 further stated, To prevent skin, break down and pressure ulcers, residents are repositioned every two hours. During an interview with the WTN, on March 16, 2026, at 10:55 AM, the WTN stated, he identified a new pressure injury on Resident 1's hip which was stage three (a tissue damage that results in full thickness loss of skin) after a CNA had reported it to him March 3, 2026. The WTN further stated, [Name of Resident 1]'s right hip area was clear and did not have any skin break before. During an interview on March 3, 2026, at 11:05 AM, with the Director of Nursing (DON), the DON stated, he was made aware of a new pressure injury, stage three, on the right hip of Resident 1, on March 3, 2026. DON further stated, Staff are supposed to do a daily skin inspection during care to report any skin changes. During a follow up interview and concurrent record review on March 16, 2026, at 11:55 AM, with the DON, the facility's policy and procedure (P&P), titled, Prevention of Pressure Injuries revised April 2020, was reviewed. The P&P indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema) . The DON acknowledged the policy and stated she expected staff to have provided care sooner.

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