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	11/14/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to protect a resident's right to be free from resident-to-resident physical abuse for 1 (Resident #216) of 3 residents reviewed for abuse. Specifically, Resident #88 hit Resident #216 with a plastic water pitcher after a verbal disagreement on 11/09/2024. Findings included: A facility policy titled, Abuse Prevention Program, revised 12/2016, indicated, As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/01/2024, indicated Resident #88 scored 11 on a Brief Interview for Mental Status (BIMS), which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #88 did not exhibit any physical or verbal behavioral symptoms directed toward others. According to the MDS, Resident #88 used a walker and wheelchair for mobility during the past seven days. An Admission Record revealed the facility admitted Resident #216 on 11/07/2024. According to the Admission Record, the resident had a medical history that included the presence of a left artificial hip joint, encounter for orthopedic aftercare, difficulty walking, and generalized muscle weakness. A Brief Interview for Mental Status (BIMS) form, dated 11/11/2024, revealed Resident #216 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #216's admission Minimum Data Set (MDS) was not completed and was not yet due at the time of the survey. An Admission/Readmission Data Collection tool, dated 11/07/2024, revealed Resident #216 arrived at the facility at 9:45 PM. The tool revealed the resident's ability to change position from sitting to lying, lying to sitting on the side of the bed, sitting to standing, transferring from the bed to a chair, and ambulation was not assessed. The tool indicated Resident #216's mood was calm and cooperative. The tool also indicated Resident #216 had a left trochanter (hip) surgical incision with a drain in place and covered with a clean bandage. (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

Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

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 11/14/2024
NAME OF PROVIDER OR SUPPLIER Rialto Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1471 S Riverside Ave Rialto, CA 92376	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #216's care plan included a focus area initiated 11/09/2024 that indicated the resident was at high risk for trauma informed care due to a recent altercation with a confused roommate. A focus area initiated 11/09/2024 indicated Resident #216 was also at risk for alterations in psychosocial well-being related to a resident-to-resident altercation. The interventions directed the staff to discuss with Resident #216 any concerns or fears regarding the incident and to explain to the resident that aggressive behavior was not acceptable. Progress Notes dated 11/08/2024 at 10:36 PM indicated Resident #216 was adjusting to the new environment and had no complaints about their roommate. A Progress Note dated 11/09/2024 at 10:56 AM indicated the nurse received a report that Resident #216 had an issue with their roommate. The note indicated when the resident was assessed, the resident was found in bed with their legs off the left side of the bed and the resident's head half off the right side of the bed. The roommate (Resident #88) was on the far side of the room. The Progress Note indicated the nurse asked what happened, and Resident #216 reported that when they had coughed, the roommate complained of the cough being too loud. Later, when the roommate coughed, Resident #216 told the roommate their cough was too loud. Resident #216 reported the roommate then hit them with the plastic water pitcher. The note indicated the floor and bed linens were wet and that Resident #216 indicated Resident #88 had hit them on the left shoulder and up toward their face. No discoloration or swelling were noted. According to the note, Resident #216 stated as the two residents struggled and as Resident #216 began falling off the bed, Resident #88's thumb entered Resident #216's mouth, and Resident #216 bit down. Resident #216 agreed to a room change. A Progress Note dated 11/09/2024 at 8:32 PM revealed Resident #216 complained of increasing pain and the need to verify their hip was okay. The Progress Note indicated Resident #216 also complained of abdominal pain and of the wound vacuum not working properly since they had almost fallen out of bed during the altercation. The note indicated the nurse suggested the resident go to the hospital for evaluation, and Resident #216 agreed. A hospital After Visit Summary, dated 11/09/2024, revealed Resident #216 was seen for hip pain and listed diagnoses including left hip pain, history of hip surgery, and head injury. The summary included the impressions of computed tomography (CT) scans and x-rays of the resident's pelvis, left femur, and head. According to the imaging results, Resident #216 had findings that suggested an abscess (tender mass filled with pus and bacteria) versus postoperative seroma (pocket of clear fluid) in the left hip/buttock area and possible loosening around the proximal aspect of the femoral prosthesis, with a collection of gas in the same area that could be postsurgical or infectious in etiology. The results of a CT scan of Resident #216's head were negative. None of the imaging reports identified any acute fracture or injury. A Progress Note dated 11/10/2024 at 11:19 AM indicated Resident #216 returned from the hospital. A Progress Note dated 11/10/2024 at 12:08 PM indicated the physician was notified of the pelvis x-ray results and of an urgent orthopedic follow-up that was ordered. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A State of California Health and Human Services Agency Report of Suspected Dependent Adult/Elder Abuse form dated 11/09/2024 indicated there had been a resident-to-resident altercation between Resident #216 and Resident #88, in which Resident #88 hit Resident #216 with a plastic water pitcher. The form indicated Resident #216 then grabbed Resident #88 who fell to the floor. As Resident #88 fell to the floor, the resident's thumb went into Resident #216's mouth and Resident #216 bit down. The residents were separated. The form indicated the date and time of the incident was 11/09/2024 at 10:45 AM. A Psychological Evaluation dated 11/12/2024 revealed through observation and reported symptoms, Resident #216 had moderate to severe depression which suggested a need for targeted mental health interventions. The evaluation indicated Resident #216 exhibited physical symptoms of anxiety but was expected to function without needing psychotherapy to manage symptoms of persistent low mood. The evaluation indicated the resident could cope effectively with any associated symptoms such as uncertainty or indecision without psychotherapy treatment. During an interview on 11/11/2024 at 1:10 PM, Resident #216 stated they arrived in the facility on 11/07/2024 at about 9:30 PM. Upon admission, they were placed in a room with Resident #88. Resident #216 stated the next morning (11/08/2024) around 10:00 AM, Resident #216 coughed, and Resident #88 stated the cough was too loud. Resident #216 stated even after using a cough drop, they coughed again, and Resident #88 again stated the coughing was too loud. At that point, Resident #216 stated Resident #88 also coughed, and Resident #216 told Resident #88 the cough was too loud. Resident #216 reported that Resident #88 then stated Resident #216 did not know who they were (expletive) with and threatened to kick Resident #216's buttocks. Resident #216 stated Resident #88 came over to Resident #216's bed and hit Resident #216 on the face with the water pitcher. Resident #216 stated Resident #88 then tried to pull Resident #216 off the bed. Resident #216 stated they grabbed Resident #88, then Resident #88 swung and hit them again. During the scuffle, Resident #88's thumb went into Resident #216's mouth, and Resident #216 bit Resident #88's thumb. Resident #216 stated Resident #88 screamed until staff arrived. Resident #216 stated staff tried to get them to let go of Resident #88, but Resident #216 told staff they were not letting Resident #88 go until they had subdued the resident, since Resident #88 had been the aggressor. Resident #216 stated they had not seen Resident #88 since the incident. Resident #216 stated a few staff had spoken to them about the incident. Resident #216 stated some staff members had reported Resident #88 had been a problem before and added they thought the facility had placed them in a dangerous situation where they had to fight. The Administrator was interviewed on 11/11/2024 at 1:30 PM and confirmed there had been an incident between Resident #216 and Resident #88. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Vocational Nurse (LVN) #1 was interviewed on 11/13/2024 at 1:57 PM and stated she found out about the incident between Resident #216 and Resident #88 when she returned to work on 11/09/2024 at 11:50 AM. She stated one of the treatment nurses and the supervisor, Registered Nurse (RN) #2, told her about the incident. LVN #1 stated she was the assigned nurse for both residents on that day. LVN #1 stated when she arrived that morning for her shift, both Resident #216 and Resident #88 were fine, and nothing was said about the residents not getting along. LVN #1 stated Resident #88 had changed rooms previously when roommates had been too loud, but added Resident #88 had no history of physical abusiveness and she had no knowledge of the resident having verbal altercations before. LVN #1 stated Resident #216 reported that Resident #88 said their cough was too loud and when they coughed again, Resident #88 started mocking Resident #216. Resident #216 then told Resident #88 they were too loud. The nurse stated Resident #216 reported that Resident #88 then approached in a threatening manner and stated Resident #216 better be quiet then hit Resident #216 on the left side of the face. LVN #1 stated Resident #216's pillowcase was wet but was not wet enough to indicate a whole pitcher of water was spilled. LVN #1 stated Resident #216 had no bruises, swelling, or cuts on their face. LVN #1 stated she had been asked by the Assistant Director of Nursing (ADON) to write a witness statement and added it was facility protocol for anyone in or around an incident to write a statement. LVN #1 stated since the incident, in-services had been held to remind staff to report abuse immediately and to remind staff if a resident-to-resident event occurred to separate the involved residents immediately. The Director of Social Services (DSS) was interviewed on 11/13/2024 at 2:13 PM. The DSS stated she was not in the facility when the incident between the residents occurred and had received her information on 11/11/2024 during the morning management meeting. The DSS stated she was unsure what had started the argument between the residents but that she had visited both residents daily since the incident. The DSS stated other interventions placed included scheduling a psychology visit and the psychosocial visits she provided. During a telephone interview on 11/13/2024 at 2:49 PM, RN #2 stated she had been made aware by a Certified Nursing Assistant (name unknown), who had reported a resident was on the floor. RN #2 stated upon her arrival in the room Resident #88 was in a wheelchair and their thumb was bleeding. Resident #216 was lying crooked on their bed. She stated LVN #3, and a respiratory therapist were in the room. RN #1 stated another CNA (she was not sure which CNA) had helped her straighten Resident #216 in the bed. Resident #216 stated Resident #88 had complained about them coughing too loudly and then when they had commented on Resident #88 coughing, Resident #88 came to their side of the room and hit them with a water pitcher. RN #1 stated the floor, Resident #216's clothing, and the bed were wet to the point that it would lead one to believe Resident #216's story was true. RN #2 stated Resident #216 indicated with hand motions that Resident #88 had hit them from the arm up toward their face, but Resident #216 had no bruising, swelling, redness, or any other signs of an impact. The RN stated she asked Resident #216 what had happened to Resident #88's thumb, and Resident #216 told her when they grabbed Resident #88, Resident #88's thumb had entered Resident #216's mouth, and Resident #216 bit down. The RN stated Resident #216 denied any acute pain. Emergency medical services (EMS) were called for Resident #88, the residents were separated into different rooms, and the Administrator and DON were notified. The RN added that before Resident #88 ever left the facility, she had started the paperwork for reporting the incident to the state agency. RN #2 stated she knew she had to have all the Is dotted, and Ts crossed, because a serious injury had occurred, and knew she only had one hour to report abuse to the state agency. RN #2 stated another RN helped her get the paperwork together and helped start getting witness statements from staff. RN #1 described Resident #88 as a grumpy resident who had issues with other roommates but had no history of physical or verbal abuse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #4 was interviewed on 11/13/2024 at 3:23 PM. RN #4 stated as a supervisor, she would be expected to complete information about abuse that was submitted to the state agency and added abuse had to be reported within two hours. RN #4 stated Resident #88 had no history of physical or verbal abuse toward others. RN #4 stated she had received in report that Resident #88 and Resident #216 were immediately separated, witness statements were received from staff, and retraining of staff was started for resident-to-resident abuse. RN #5 was interviewed on 11/13/2024 at 3:38 PM. RN #5 stated she learned about the incident when she arrived for her evening shift. When she arrived at work, Resident #88 was at the hospital. RN #5 stated initially, Resident #216 refused to go to the hospital, but later when she checked on the resident, the resident had different pain than the surgical pain and was reporting groin pain. RN #5 stated Resident #216 agreed to go to the hospital for evaluation, left on the 3:00 PM to 11:00 PM shift, and returned to the facility after 11:00 PM. RN #5 stated she found out the surgical site had loosened, and an orthopedic appointment was ordered as soon as possible. RN #5 described Resident #88 as cranky but not physically abusive. An interview was held with Resident #88 on 11/14/2024 at 8:45 AM. Resident #88 remembered a fight but was unable to identify the resident. Resident #88 stated the other person had bit his finger off. Resident #88 stated the other person was mad because Resident #88 had told the other resident to go to hell. Resident #88 denied throwing water on the other resident or hitting the other resident. At the time of the survey, Resident #88 resided in a room on the other side of the facility from Resident #216 and did not have a roommate. LVN #3 was interviewed on 11/14/2024 at 9:02 AM. LVN #3 stated when she arrived in the room, Resident #88 was outside the room with the treatment nurse and Resident #216 was on their bed. LVN #3 stated she was aware the police spoke to the residents. The LVN stated after the incident, the two residents were immediately separated. LVN #3 stated since the incident, the facility had started retraining staff on resident-to-resident abuse, which included how to separate residents and how to calm residents. Interviews were held with Resident #216's roommates on 11/14/2024 at 10:45 AM. Resident #2, Resident #80, and Resident #217 stated they had had no issues with Resident #216. The Assistant Director of Nursing (ADON) was interviewed on 11/14/2024 at 11:12 AM. The ADON stated she found out about the incident via a call from staff on the day it happened but was unsure who called her. The ADON stated training was initiated about abuse on the day of the occurrence and the two residents were separated. The two residents had received social service visits and psychological visits to help with any psychosocial issues. The ADON stated the two involved residents were placed on opposite sides of the building and, to the best of her knowledge, had not seen each other since the incident. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 11/14/2024 at 2:07 PM. The DON stated RN #2, who was the supervisor, called to alert her of the incident right after the incident occurred. The DON stated she directed staff to make sure the residents were separated, assess the residents, notify the family members, notify the police, and submit the allegation of abuse to the state agency. The DON stated she spoke with Resident #216 on 11/11/2024, and the resident told her the incident was self-defense. The DON stated Resident #88 could be verbally aggressive but had no history of physical aggression. She stated Resident #88's verbal aggression consisted of the way they spoke to other residents and yelled at other residents for being too loud and stated some considered Resident #88 rude. The DON stated Resident #88 and the last roommate got along well, but the roommate discharged home. The DON stated after the incident, in-services were started on resident-to-resident altercations and the facility had decided to start a 72-hour monitoring process after resident-to-resident incidents like what they did for new admissions or for room changes. The DON stated RN #2 started gathering witness statements on the day of the incident and the residents were moved to opposite sides of the building. The DON stated to the best of her knowledge, the two residents had not seen each other since the incident, adding that Resident #88 did not travel throughout the building and Resident #216 stayed on their side of the building. The Administrator was interviewed on 11/14/2024 at 2:36 AM. The Administrator stated he found out about the incident from RN #1 on the day the incident occurred. The Administrator stated the DON was the one who gave guidance to the staff. He stated the residents were separated and were sent to the hospital, the staff were monitoring the involved residents, and in-services had started. The Administrator stated Resident #88 had behaviors but had no prior incidents of physical abuse. The surveyor attempted to conduct a telephone interview on 11/14/2024 at 2:45 PM with the Respiratory Therapist (RT) who responded first to the residents' room on the date of the incident. However, the RT's cell phone voice mailbox was full, and it was not possible to leave a message. During a follow-up interview with Resident #216 on 11/14/2024 at 3:31 PM, Resident #216 stated when Resident #88's thumb went into their mouth, the bite just happened. The surveyor was unable to determine if the bite was deliberate or reflexive.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 46258 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 3 (Residents #22, #97, and #119) of 33 residents reviewed for MDS accuracy. Findings included: A facility policy titled, Resident Assessments, revised 10/2023, specified, All persons who have completed any portion of the MDS resident assessment must sign the document attesting to the accuracy of such information. 1. An Admission Record revealed the facility admitted Resident #22 on 12/10/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of schizophrenia. A significant change MDS, with an Assessment Reference Date (ARD) of 06/10/2024, indicated Resident #22 did not have a Level II Preadmission Screening and Resident Review (PASRR). A quarterly MDS, with an ARD of 09/06/2024, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #22 had a diagnosis of schizophrenia. A letter dated 12/14/2023 from the State of California - Health and Human Services Agency Department of Health Care Services revealed a Level II PASRR evaluation was completed for Resident #22 on 12/12/2023. During an interview on 11/14/2024 at 11:45 AM, the MDS Assistant stated the Level II PASRR should have been coded on Resident #22's MDS. During an interview on 11/14/2024 at 1:51 PM, the DON stated the Level II PASRR should have been included on the MDS. During an interview on 11/14/2024 at 2:27 PM, the Administrator stated the Level II PASRR should have been included on the MDS. 2. An Admission Record revealed the facility admitted Resident #119 on 12/01/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of hemiplegia. A quarterly MDS, with an Assessment Reference Date (ARD) of 08/19/2024, revealed Resident #119 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #119 received insulin injections. The MDS did not indicate Resident #119 had diabetes mellitus. Resident #119's care plan included a focus area initiated 03/13/2024 that indicated Resident #119 had diabetes mellitus. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/2024 at 11:45 AM, the MDS Assistant stated Resident #119's diabetes mellitus diagnosis should have been indicated on the MDS. During an interview on 11/14/2024 at 1:51 PM, the DON stated the diabetes mellitus diagnosis should have been indicated on the MDS. During an interview on 11/14/2024 at 2:27 PM, the Administrator stated the diabetes mellitus diagnosis should have been indicated on the MDS. 45849 3. Resident #97's Admission Record indicated the facility admitted the resident on 07/02/2024. According to the Admission Record, the resident had a medical history that included diagnoses of bipolar disorder, Parkinson's disease, anxiety, and adjustment disorder with mixed anxiety and depressed mood. A Notice of PASRR [Preadmission Screening and Resident Review] Level I Screening Results letter dated 07/03/2024 indicated Resident #97's Level I PASRR screening was positive for a serious mental illness and that a level two mental health evaluation referral was required. A Notice of Individual Determination letter, dated 07/05/2024 and sent from the California Department of Health Care Services to the facility, revealed Resident #97's Level II PASRR evaluation was completed on 07/05/2024. The attached Categorical Determination Report, also dated 07/05/2024, revealed Resident #97 had a significant medical condition with mental stressors that required nursing care. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2024 (three days after the Level II PASRR evaluation was completed), revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #97 was not currently considered by the state Level II Preadmission Screening and Resident Review (PASRR) process to have a serious mental illness. The MDS indicated Resident #97 had psychiatric diagnoses that included anxiety disorder and bipolar disorder. In an interview on 11/14/2024 at 11:46 AM, the MDS Assistant stated she got information for completing the MDS from the resident's medical record, interviews, therapy, and the PASSR portal. She also stated Resident #97 had a Level II PASSR and this should have been indicated on the MDS. In an interview on 11/14/2024 at 1:51 PM, the Director of Nursing (DON) stated the MDS nurse should look in the hospital records, medical record, and the PASSR information when they completed the MDS. The DON stated if Resident #97 had a Level II PASSR that indicated mental illness, this should be indicated on the MDS. In an interview on 11/14/2024 at 2:27 PM, the Administrator (ADM) stated the MDS nurse should use interviews, the medical record, and hospital records when completing the MDS. The ADM stated the MDS should look up the PASRR information also and that every Level II PASRR should be captured on the MDS.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to ensure potentially hazardous medications were secured to prevent potential accidents for 2 (Resident #104 and Resident #75) of 3 residents reviewed for accidents. Findings included: The facility policy titled, Self-Administration of Medications, revised 02/2021, revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy further indicated, Any medications found at bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. An Admission Record revealed the facility admitted Resident #104 on 02/20/2023. According to the Admission Record, Resident #104 had a medical history that included generalized muscle weakness, unspecified dementia, and unspecified hyperlipidemia (elevated cholesterol levels). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2024, revealed Resident #104 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #104 was able to understand others, be understood when speaking, and had adequate vision with the use of corrective lenses. The MDS revealed Resident #104 had no functional limitation in range of motion of the upper extremities, required only set-up or clean-up assistance from staff for eating, and required supervision or touching assistance from staff with personal hygiene. Resident #104's care plan included a focus area, initiated on 02/21/2023, that revealed the resident had an alteration in cognitive function related to dementia, coronary artery disease, chest pain, and a stroke. Interventions directed staff to monitor the resident and report to the physician any changes in cognitive function, decision making ability, recall, memory, and general awareness. Self-administration of medication was not included as a focus area on the care plan. Resident #104's Order Summary Report for the period ending 11/01/2024 did not include an order for the resident to self-administer medications or to keep medications at the bedside. An observation on 11/11/2024 at 10:20 AM revealed a cup of pills on Resident 104's over-bed table, which was positioned to the left of the resident and within the resident's reach. Within the medication cup was one white pill and one tan colored pill. Resident #104 stated the nurse had left the medication to be taken when the resident ate, but Resident #104 stated they had forgotten to take the medication. Licensed Vocational Nurse (LVN) #1 entered Resident #104's room on 11/11/2024 at 10:23 AM. LVN #1 stated she was not assigned to care for Resident #104 and identified LVN #7 as the nurse assigned to Resident #104. LVN #1 removed the cup of medication from the resident's room and stated medications should not be left at a resident's bedside. (continued on next page)

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 11/14/2024

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN #7 was interviewed on 11/11/2024 at 10:25 AM and confirmed he was assigned to care for Resident #104. LVN #7 stated he had given Resident #104 their medications and had watched the resident take all the medications he had taken into the room. LVN #7 stated he did not know who had left the medication at Resident #104's bedside. LVN #7 denied seeing medication at the resident's bedside when he was in the room earlier and stated medications should not be left at a resident's bedside. Registered Nurse (RN) #4 was interviewed on 11/13/2024 at 3:29 PM. The RN identified herself as the evening shift supervisor. RN #4 stated there were no residents in the facility who self-administered medications and added that staff were not allowed to leave medications at the bedside. RN #4 stated if medications were left at the bedside, and the resident was cognitively impaired, the resident may not take the medication. RN #4 identified Resident #104 as cognitively impaired and stated medications should not be left at the resident's bedside. The RN added she would not trust Resident #104 to take medications. During an interview on 11/13/2024 at 3:46 PM, LVN #8 stated she had been the nurse assigned to Resident #104 on the evening shift on 11/10/2024. The nurse reviewed the resident's orders and stated that on the evening shift, Resident #104 received Brilinta (a medication that prevents blood clots and lowers the risk of heart attack and stroke) 90 milligrams (mg), atorvastatin (a medication for high cholesterol that comes in a white tablet form) 80 mg, and Colace (a medication to prevent constipation and comes in a tan colored round pill). The LVN stated she had taken these to Resident #104 and denied leaving the medications at the bedside. LVN #8 stated she made sure Resident #104 took the medications and she was unsure how the medications were left at the bedside. Certified Nursing Assistant (CNA) #9 was interviewed on 11/13/2024 at 3:51 PM. CNA #9 stated she had not seen medications at Resident #104's bedside, and if she found medication at a resident's bedside, she would report this to the nurse. CNA #10 was interviewed on 11/14/2024 at 9:07 AM. CNA #10 stated if medications were seen at the bedside, she would remove the medication and give it to the charge nurse. CNA #10 stated she had worked on 11/11/2024 but had not seen medication left at Resident #104's bedside. CNA #10 stated Resident #104 would not remember to take medication left at the bedside. LVN #7 was interviewed on 11/14/2024 at 10:10 AM. LPN #7 removed the medications from the cart that Resident #104 was scheduled to receive on the evening shift and verified the large white tablet (atorvastatin) and the tan (beige) tablet (Colace) were the ones he had seen in the cup that had been found in Resident #104's room on 11/11/2024. LVN #7 stated he would not have left medication in the resident's room because it was not policy. LVN #7 stated Resident #104 did not have the mental capacity to remember to take medications, even if they were left in the room, adding that the resident's short-term memory was impaired and the resident was not able to remember when someone had been in the room. LVN #7 stated that while there were no wanderers who lived on the hall where Resident #104 lived, there were other residents in the facility that wandered and there was a danger of wandering residents taking the wrong medication and having a reaction. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Assistant Director of Nursing (ADON) was interviewed on 11/14/2024 at 10:51 AM. The ADON stated medications should be administered to the resident and no pills left in the room. The ADON stated Resident #104 had not been assessed to self-administer medications. The ADON stated that prior to self-administration, a resident's competence to self-administer had to be determined, the physician made aware of the resident's desire to self-administer, an order received for self-administration, and the interdisciplinary team (IDT) had to determine if the resident was competent to self-administer. The ADON stated medications left in a resident's room had to be in a locked box, and physician's orders had to be followed for administration of medications. The Director of Nursing (DON) was interviewed on 11/14/2024 at 2:01 PM. The DON stated she did not expect nurses to ever leave medications at the bedside. The DON stated Resident #104 was not appropriate for self-administration because the resident had a low BIMS and fluctuating mental capacity. The DON stated wandering residents could take the medication and either double up on medication or have an allergic reaction. The Administrator was interviewed on 11/14/2024 at 2:31 PM. The Administrator stated he did not expect nurses to leave medications at bedside. The Administrator stated Resident #104 had a fluctuating cognitive status. 2. An Admission Record revealed the facility admitted Resident #75 on 01/15/2024 and most recently readmitted the resident on 10/26/2024. According to the Admission Record, Resident #75 had a medical history that included end stage renal disease with a dependence on renal dialysis, polyneuropathy, and primary generalized osteoarthritis. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/2024, revealed Resident #75 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #75 was able to understand others, be understood when speaking, and had adequate vision with the use of corrective lenses. The MDS revealed Resident #75 had no functional limitation in range of motion of the upper extremities, required only set-up or clean-up assistance from staff for eating, and required partial/moderate assistance from staff with personal hygiene. Resident #75's care plan, revised 07/18/2024, did not include a focus area to address self-administration of medication. Resident #75's Order Summary Report for the timeframe ending 11/01/2024 did not include an order for the resident to self-administer medications or to keep medications at the bedside. There was no order for Pain Wizard Natural Relief. An observation on 11/11/2024 at 11:03 AM revealed the resident had a roll-on applicator of Pain Wizard Natural Relief that was used for arthritis. Ingredients listed on the applicator bottle included camphor, menthol, capsaicin, and methylsulfonylmethane (MSM - a compound that has anti-inflammatory properties and plays a key role in making collagen and glucosamine). Resident #75 stated they also had a larger pump bottle of the medication on the nightstand and indicated the nurses knew the medication was at the bedside. During an observation on 11/13/2024 at 11:15 AM, the roll-on applicator bottle and pump bottle of Pain Wizard Natural Relief remained in Resident 75's room. (continued on next page)

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Rialto Post Acute Center	1471 S Riverside Ave Rialto, CA 92376

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse (RN) #4 was interviewed on 11/13/2024 at 3:29 PM. The RN identified herself as the evening shift supervisor. RN #4 stated there were no residents in the facility who self-administered medications and added that staff were not allowed to leave medications at the bedside. RN #4 stated if medications were left at the bedside, and the resident was cognitively impaired, the resident may not take the medication. Certified Nursing Assistant (CNA) #9 was interviewed on 11/13/2024 at 3:51 PM. CNA #9 stated she had not seen medication at Resident #75's bedside, and if she found medication at a resident's bedside, she reported it to the nurse. CNA #9 stated this included over-the-counter medications including arthritis rubs. CNA #9 went into Resident #75's room and looked at the roll-on dispenser. The CNA stated she thought the roll-on container was deodorant and added that she would report the medication to the nurse. CNA #10 was interviewed on 11/14/2024 at 9:17 AM. CNA #10 stated she had previously worked with Resident #75 and had seen a roll-on container at the bedside but identified the container as deodorant. She stated she had seen the resident applying lotion independently but was unaware of what the lotion may have been. Licensed Vocational Nurse (LVN) #7 was interviewed on 11/14/2024 at 10:38 AM. The LVN stated over the counter (OTC) medications should not be stored at a resident's bedside. He stated he was unaware Resident #75 had OTC medications in their room but knew now the medications had been removed from the resident's room. LVN #7 stated he had not seen any pain medication in Resident #75's room. LVN #7 stated the nurses on the hall were responsible for the completion of the medication self-administration assessments, and to be best of his knowledge, one had not been completed for Resident #75. The Assistant Director of Nursing (ADON) was interviewed on 11/14/2024 at 11:06 AM. The ADON stated she would need to review Resident #75's chart to see if the resident had been assessed for self-administration or had an order for the arthritis rub. The ADON stated she expected the policy for self-administration of medications to be followed and if Resident #75 had not been assessed for self-administration, then the medication was not to be in the resident's room. The Director of Nursing (DON) was interviewed on 11/14/2024 at 2:04 PM. The DON stated if an OTC medication was found in a resident's room, staff should see if there was an order, and if there was no order, the medication should be removed. She stated staff should see if the resident had been assessed for self-administration of medication and if they had not, then staff should complete the assessment. The DON stated medication should not be kept on the resident's over-bed table or on the nightstand. The DON stated she was unsure if Resident #75 had an order for the medication or had been assessed for self-administration prior to 11/13/2024. The Administrator was interviewed on 11/14/2024 at 2:31 PM and stated he did not expect OTC medications to be left at the bedside unless there was a care plan and order for the medication. The Administrator stated he did not expect Resident #75 to have medication at their bedside.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to provide urinary catheter care in a manner to minimize the potential for urinary tract infection (UTI) or other complications for 1 (Resident #52) of 2 residents reviewed for urinary catheter care and services. Facility staff failed to follow clean technique and rinse the soap from the resident's skin during urinary catheter care and failed to properly position the urinary catheter drainage bag to facilitate drainage. Findings included: A facility policy titled, Catheter Care, Urinary, revised 09/2014, specified, Change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the above technique. The policy also indicated, Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. Additionally, the policy revealed that staff should, Be sure the catheter tubing and drainage bag are kept off the floor. An Admission Record revealed the facility admitted Resident #52 on 06/21/2023 and most recently readmitted the resident on 07/19/2024. According to the Admission Record, the resident had a medical history that included a Stage IV sacral pressure ulcer and type 2 diabetes mellitus with hyperglycemia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/11/2024, revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS also indicated Resident #52 was dependent on staff for completion of all activities of daily living and had an indwelling urinary catheter. Resident #52's care plan included a focus area, initiated 07/21/2024, that indicated the resident had an indwelling catheter related to a neurogenic bladder. An intervention directed staff to provide catheter care. An Order Summary Report that listed active orders as of 11/01/2024 indicated Resident #52 needed the indwelling urinary catheter due to a neurogenic bladder. The report also included a physician's order initiated 07/19/2024 that directed staff to complete catheter care every shift. On 11/14/2024 at 12:47 PM, an observation was made of Certified Nursing Assistant (CNA) #6 completing catheter care for Resident #52. The CNA donned gloves and gown. CNA #6 then took a large bath towel into the bathroom to wet the towel. CNA #6 stated she applied soap from the soap dispenser onto the towel. The CNA then took the towel and wiped the resident's left groin and right groin without changing to a clean area of the towel. Still without changing areas of the towel, CNA #6 wiped the catheter from the insertion site outward then washed the resident's perineum. CNA #6 did not rinse the soap from Resident #52 and did not dry the resident's skin prior to applying a clean brief. When CNA #6 completed catheter care, she lowered the bed, allowing the catheter drainage bag to lie flat inside a basin that was on the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was held with CNA #6 on 11/14/2024 at 12:55 PM. CNA #6 stated she had been taught to use different sections of the cloth when providing catheter care to avoid infection but forgot to use different sections when caring for Resident #52 due to nervousness. CNA #6 acknowledged she had not rinsed the soap from the resident's skin and stated she had been taught the soap needed to be removed. CNA #6 stated she was nervous and forgot to rinse the soap from the resident's skin. As the CNA left the room, she was reminded to check on the position of the urinary drainage bag. CNA #6 stated the bag should not be lying on the floor inside the basin and removed the bag from the basin and hung the drainage bag on the bedrail. The Director of Nursing (DON) was interviewed on 11/14/2024 at 2:16 PM. The DON stated that during incontinence care, the CNA was expected to change the cloth they used when cleaning or to change the area of the cloth used during the provision of care. The DON stated she expected the soap to be rinsed off the resident to prevent buildup of soap residue. The DON added the urinary drainage bag should be below the level of the bladder but not lying flat. The DON added that with the urinary drainage bag lying flat, the position of the drainage bag prevented gravity from emptying the bladder. The Administrator was interviewed on 11/14/2024 at 2:35 PM. The Administrator stated he expected the policy for catheter care to be followed to reduce the risk of infection.