

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
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 01/08/2026
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)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure adequate supervision and safe environment to prevent elopement for one of five residents (Resident 175), reviewed for accidents. On January 7, 2026, Resident 175 (a resident diagnosed with Parkinson's disease [a brain disorder that causes tremors, slowed movement, poor balance, and difficulty with walking and coordination, increasing fall and wandering risks] and at high risk for falls) exited the facility through an alarmed emergency exit door, unsupervised. As a result, Resident 175 was found by the local police approximately one mile from the facility and was then transported by ambulance to the hospital for evaluation. This failure placed Resident 175 at risk for serious harm, injury or death including but not limited to traffic injury, exposure to environmental hazards, and inability to seek help. Resident 175 was found with a large bruise on his left hip, lacerations on his feet and on his knees. During a review of Resident 175's admission Record (contains demographic and medical information), indicated Resident 175 was admitted to the facility on [DATE], with diagnoses which included Parkinson's disease (a disorder that causes tremors, slowed movement, poor balance, and difficulty with walking and coordination, increasing fall and wandering risks) sequelae of cerebral infarction (a long term brain damage from prior stroke that can cause weakness, impaired judgment, confusion and poor safety awareness) and lack of coordination (difficulty controlling body movements and balance, making walking unsafe and increasing risk for falls and injury). During a review of Resident 175's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing home residents) Section C (Cognitive (involving conscious intellectual activity) patterns), dated January 6, 2026, indicated Resident 175 had a BIMS (brief Interview for Mental Status - tool used to screen how a resident is functioning cognitively) score of 12 (a BIMS score of 8-12 suggests resident is moderately impaired). During a continued review of Resident 175's MDS, Section GG (Functional Abilities) dated January 6, 2026, indicated: .J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet (about 15 meters) and make two turns, coded 88 (Not attempted due to medical condition or safety concerns), .K. Walk 150 feet: Once standing, the ability to walk at least 150 feet (about 46 meters) in a corridor or similar space, coded 88, .L. Walking 10 feet on uneven surfaces: The ability to walk 10 feet on uneven or sloping surface (indoor or outdoor), such as turf or gravel, was coded 88, .M. 1 step (curb): The ability to go up and down a curb and/or up and down one step, was coded 88. During a review of a document titled, SOC 341 (a document used by mandated reporters to document and report suspected abuse (physical, financial, neglect, etc.) of elders (60+ years old) or dependent adults (18-[AGE] years old)), dated January 7, 2026, the SOC 341 indicated, Patient [Pt - Resident 175], was brought in by ambulance and [name of local police department] (PD) after being found in the The Wash (a natural drainage channel or wash that runs through the city, used for flood control). Per PD, they received a call for service about Pt waking in a hospital gown and socks with blood on him. PD received a second call indicating Pt was seen in the wash. PD confirmed to have located Pt in the wash a mile down from [name of the facility]. PD contacted the facility and drove to the facility to confirm Pt was from the facility. Per PD, Staff reported Pt was last seen 7-8 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055213	Facility ID: 055213 If continuation sheet Page 1 of 19

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hours prior to being found. Per PD, staff was unable to inform PD when and how Pt was able to leave the facility. Per PD, staff reported Pt has history of Parkinson's, Dementia (decline in mental abilities), and is a fall risk. During an interview on January 7, 2026, at 2:26 PM, with the Administrator (ADMIN), in her office, the ADMIN stated, Resident 175 was admitted to the facility on [DATE], with medical diagnoses of Parkinson's disease and dysphagia (difficulty swallowing). The ADMIN further stated in the morning of January 7, 2026, Resident 175 informed his nurse that he wanted to go out to get some fresh air. ADMIN further stated she was made aware of Resident 175 being transported to the hospital at approximately 9:30 AM after the local police arrived at the facility. During an interview on January 7, 2026, at 2:34 PM, with the Licensed Vocational Nurse / Treatment Nurse (LVN 1), the LVN 1 stated Resident 175 was admitted on [DATE] or 2, of 2026. LVN 1 stated the last time she saw Resident 175 was in the hallway walking with his wheelchair. LVN 1 stated Resident 175 appeared to be thinking about what he was going to do but not headed in any specific direction. LVN 1 stated Resident 175 was alert, oriented (a person who is aware of their identity, surroundings, and the current time), and ambulatory (a person who can walk or move independently). LVN 1 stated she was not aware of any behavioral issues, or special safety precautions in place for Resident 175. LVN 1 stated Resident 175 had a history of homelessness and had not observed any elopement behavior. During a further interview on January 7, 2026, at 2:36 PM, with LVN 1, LVN 1 stated Resident 175 had told his nurse (LVN 3) he wanted to go outside to get some fresh air and an Out on pass (OOP - a formal physician's authorization for patients to temporarily leave for a set period of time) physician's order was obtained, and she was the nurse who obtained the order. Subsequently, during a concurrent interview and record review conducted on January 7, 2026, at 2:38 PM, with LVN 1, Resident 175's OOP order dated January 7, 2026, at 10:21 AM (at approximately 3 hours after Resident 175 left the building), was reviewed. The OOP order indicated, May go out on pass for 4 hours. LVN 1 stated the OOP order was entered after Resident 175 had already exited the facility and there was no previous order for Resident 175 to be out on pass. During an interview on January 7, 2026, at 4:07 PM, with the acute hospital Social Worker (SW). The SW stated Resident 175 arrived at the hospital at approximately 9:15 AM, on January 7, 2026. The SW stated the Police Department received a call reporting that an individual was walking down the street on a hospital gown and socks, with blood on them, which caused concern. The SW stated two vehicles were sent to search for the individual. The SW further stated that law enforcement initially searched for the individual but did not locate him. Later, PD received a second call reporting that (Resident 175) was in the wash. The SW further stated PD found Resident 175 with lacerations on his feet and on his knees. He also had a large bruise on his left hip. The SW stated Resident 175 was found approximately one mile away from the facility. The law enforcement went to the facility and confirmed the resident (Resident 175) belonged to them. The facility informed PD Resident 175 had Parkinson's disease, dementia, and was at risk for falls. During an interview on January 7, 2026, at 4:25 PM, with the Director of Nursing (DON), the DON confirmed that Resident 175 was admitted to the facility on [DATE], with medical diagnoses of Parkinson's and dysphagia, and that he was ambulatory with assistance. The DON confirmed that the admission assessment was completed on admission. During a concurrent interview and record review on January 7, 2026, at 4:38 PM, with the DON, DON reviewed Resident 175's Nursing - Fall Risk Evaluation, dated January 2, 2026, at 10:41 PM. The evaluation indicated Resident 175 fall score was 14, . Category: high fall risk. 1. Mental status: 2. disoriented x 3 (person, place, and time) . 2. History of Falls: 3 or more falls in the past 90 days. 3. Ambulatory/Continence: 2. Wheelchair/bed bound (assist with elimination) . The Fall Risk Evaluation also indicated Resident 175 had diagnoses that could contribute to falls, and was taking 1 or 2 medications within the last seven days that could increase the risk of fall. The DON confirmed the evaluation indicated that the resident was disoriented, had a history of multiple falls, and required assistance for mobility. During a review of Resident 175's Change in Condition Evaluation, dated January 7, 2026, at 9:27 AM, it indicated 1. Signs and Symptoms identified. 31. Other change in condition, .1a. List the other change: resident had (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a fall outside, . 3. Review Findings and Provider Notifications. 4. Summarize your observations evaluation and recommendations: resident (Resident 175) had stated to staff that (he) wanted to go outside for some fresh air. Upon this walk he fell into the driveway of the facility. A police car was pass by and assisted the resident. They (the police) decided to all (call) the 911 and send the resident to the hospital despite us advising them we had the means to care for the resident in house. Resident 175's Change in Condition Evaluation, indicated vital signs (blood pressure, temperature, respiration, heart rate) were taken at the facility at 9:35 AM and the physician was notified on January 7, 2026, at 00:00 (midnight), the evaluation was signed by LVN 1. During a review of Resident 175's Nursing Admit/Readmit Data Collection and Baseline, dated January 2, 2026, at 10:38 PM, it indicated, A. admission Information. N. Pertinent diagnosis (es): CVA (Cerebral Vascular Accident - stroke) with mild right-side weakness, . 2. LOC (Level of Consciousness)/Orientation A. LOC. 1. Alert. B. Orientation, 1. Person (Self), 2. Place (location). 4. Skin condition, .40) left knee (rear): scattered (different areas) scabs, no open areas, . 41) Right lower leg (front): scattered scabs no open areas., 5. Pain/Fall Risk. Fall Risk. A. Is the resident at risk for falls? 1. Yes. A1. Fall Care Plan. Goal: The resident's risk for injury will be minimized through the review date. Interventions: Ensure that the resident is wearing appropriate footwear when ambulation or mobilizing in w/c (wheelchair). During a concurrent interview and record review on January 7, 2026, at 4:35 PM, with the DON, the DON confirmed that the SBAR (Situation, Background, Assessment, Recommendation - used to standardize and improve the clarity of information exchange between healthcare professionals), dated January 7, 2026, was completed by LVN 1 after the facility was contacted by law enforcement. The DON further confirmed there was no prior SBAR documentation indicating Resident 175's ability to leave the facility safely nor being assessed or approved by a physician. During a review of Resident 175's hospitals record provided by the facility, titled, Fall Risk Assessment (Morse Fall Scale - a tool healthcare providers use to predict a patient's likelihood of falling), dated January 7, 2026, at 09:16 AM, the record indicted Resident 175's Morse Fall Risk Score was assessed as 55 (High fall risk). During a review of Resident 175's facility provided hospital records, the ED (Emergency Department) provider Notes, dated January 7, 2026, at 9:38 AM, indicated, Resident 175 had a past medical history of stroke, COPD, (chronic obstructive pulmonary disease, a long - term lung disease that makes it hard to breath), Parkinson's, type 2 DM (Type 2 diabetes mellitus, a chronic condition where the body does not properly use insulin, causing high blood sugar), chronic anemia (a long term condition where the blood does not carry enough oxygen), CKD, (Chronic Kidney Disease - a long term condition where the kidneys do not work properly), paroxysmal A-fib (atrial fibrillation - an irregular heart rhythm that comes and goes, which causes dizziness) and hypertension (high blood pressure) is brought in by ambulance after law enforcement found patient walking outside in the cold this morning. Patient (Resident 175) has abrasions (injury to the surface of the skin cause by rubbing or impact) to bilateral (both) knees and bilateral feet, as well as bruising (bleeding under the skin caused by an injury, which can indicate tissue damage or internal bleeding) to left hip. Social history, alcohol use: Comment: patient confused no family at bedside. Physical Exam indicated, Skin. abrasions are present to bilateral knees and feet. There is bruising to the left hip (pictures were included in the ED report). During an observation on January 7, 2026, at 6:38 PM, with the ADMIN, in the presence of the DON, Assistant Director of Nursing (ADON), and Director of Clinical Operations (DCO), the facility ?s video surveillance system footage was reviewed. The surveillance system video showed on January 7, 2026, at approximately 7:30 AM, Resident 175 exited his room wearing a white T-shirt, blue hospital-like pajama pants, and socks. Resident 175 began walking down the hallway toward the rear emergency exit. Two nursing staff were standing near nurses' station by the hallway where Resident 175 was walking. The video showed Resident 175 walking directly past the two-nursing staff without any staff approaching, speaking to, re-directing or accompanying the resident. The video then showed Resident 175 approached the rear emergency exit door, which was marked with a STOP and Emergency Exit Only signage, equipped with a push-bar exit mechanism, and an audible alarm system (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that requires a key to silence. Resident 175 removed the elastic band that had been placed across the door, pushed the alarmed exit door open, and exited the building without staff assistance or supervision. After exiting the building, Resident 175 was observed on video walking outside the facility toward the front of the building (by the main street), with an unsteady gait (a manner of walking or moving on foot) appearing off balance, but continued walking away from the facility. The video showed: 7:30 AM Resident exited his room. 7:32 AM Resident passed through the front parking lot. 7:34 AM Resident continue toward the alley and driveway leading to the main street. Facility leadership (ADMIN, DON, ADON, and DCO) who were present during the review acknowledged that the video surveillance did not show: Any staff responding to the alarm. Any staff attempting to stop the resident. Any staff turning off the alarm. Any staff following the resident to ensure his safety. Resident 175 fell into the driveway of the facility. A police car passed by and assisted Resident 175. An ambulance taking Resident 175 to the hospital. The video surveillance also indicated two local police vehicles arriving at the facility on January 7, 2026, at approximately 8:56 AM and leaving at approximately 9:09 AM. There was no resident, staff, nor ambulance visible on the video when the local police arrived. During a review of Resident 175's facility provided hospital records, the ED events, dated January 7, 2026, it indicated, ED Events, January 7, 2026, triage started (the first medical screening done when a patient arrives at the emergency room to quickly check how sick or injured, they are) 9:16 AM. During a concurrent record review and interview on January 7, 2026, at 5:31 PM, with the Director of Rehabilitation (DOR), Resident 175's Physical Therapy PT Evaluation & Plan Treatment, dated January 6, 2026 - February 4, 2026, was reviewed. The PT evaluation & plan of treatment, indicated, Reason for Referral / current illness: Patient referred to PT due to decline in strength, functional ambulation, dynamic balance and functional mobility., recent hospitalization to (name of hospital) on December 30, 2025 w/ (with) c/c (complaining of) Rt (right) side weakness and slurred speech on arrival pt (patient) endorses multiple mechanical falls cause by loss of balance, weakness, tripping), Dx: (diagnosis) CVA (stroke, loss of blood flow to the brain), AKI, (acute kidney injury, sudden kidney dysfunction causing weakness and confusion), DM (diabetes mellitus, high blood sugar, causing weakness and dizziness), Parkinson's disease. The DOR stated Resident 175 was able to ambulate with CGA (Contact Guard Assist - a caregiver or therapist maintains light, physical touch (like one or two hands on the torso) to prevent falls during activities like walking or transferring, without doing the actual work). The DOR stated Resident 175 had right-side body weakness and instability to be steady whenever he walks and someone needs to be with him. The DOR further stated Resident 175 was currently receiving physical therapy services. During a concurrent record review and interview on January 7, 2026, at 5:42 PM, with the DOR, the Resident 175's Occupational Therapy OT Evaluation & Plan of Treatment dated January 5, 2026 - February 3, 2026. The OT evaluation & plan of treatment, indicated Reason for skilled Services: Patient requires skilled OT services to develop and instruct in exercise program, develop and instruct on compensatory strategies, increase functional activity tolerance, increase safety awareness, maximize independence with ADLs (activities of daily living, as dressing bathing), Risk Factors: due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: falls and increase dependency., Physical / Cognitive/ Psychosocial Performance: Patient presents with impairments in balance, mobility, strength, use of copying strategies and use of environmental modification strategies resulting in limitations and / or participation restrictions. The DOR stated Occupational Therapy (OT) evaluation was completed on January 5, 2026, and Physical Therapy (PT) evaluation was completed on January 6, 2026, and the evaluations were used by the facility to determine Resident 175's functional status. During a follow up interview on January 7, 2026, at 6:52 PM, with the DON, the DON stated the alarm for facility's rear exit door was turned on at the time Resident 175 exited the building, and the alarm requires a key to silence. The DON further stated licensed nurses carry the keys used to turn off the alarm. The DON acknowledged the surveillance video did not show any staff member turning off the alarm or (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	responding to the alarm when Resident 175 exited the building. The DON stated the alarm activates when the emergency exit door is pushed. During an interview on January 7, 2026, at 6:48 PM, with Resident 175, in his room upon return from the hospital, Resident 175 was awake, lying down on his back in bed. When Resident 175 was asked about the current year, he stated it was 2000. Resident 175 had continuous tremors on both hands (involuntary, rhythmic shaking) and were present throughout the interview. Resident 175 stated he walked to the cement and crossed the street. When asked if he remembered what happened after that, Resident 175 stated he could not remember, he came from the hospital and I try to get healed. When asked who transported him to the hospital, Resident 175 stated he did not know; and was unable to identify whether police or ambulance were involved. Resident 175 stated he told a nurse he was going to go that way, but was unable to specify where. During this portion of the interview, Resident 175 speech was disorganized and frequently closed his eyes. During a concurrent observation and interview on January 7, 2026, at 6:55 PM, with Licensed Vocational Nurse (LVN 2) in Resident 175 room, LVN 2 conducted a body assessment of Resident 175. LVN 2 removed Resident 175's hospital socks, which were visibly stained with blood. Resident 175 stated his feet and legs hurt. Upon removal of the socks, LVN 2 exposed red tissue to an open area on the bottom of the right great toe, open areas on the left great toe and second toe. There were open red areas on Resident 175's bilateral knees and a large dark purple bruise extending from the left hip down to the mid-thigh. In addition, Resident 175 had bluish on both shoulders. LVN 2 stated the open areas on the knees, feet, left hip, and thigh were new. During a record review of Resident 175's Nursing Progress Note, dated January 7, 2026, at 7:25 PM, the following was indicated: Re admission assessment done, by LVN 1 The nursing progress note indicated: Left knee abrasion (scraped skin) (measuring) 6 x 4 cm (about 2 1/2 inches long and 1 1/2 inches wide) (with) 100% granulation (new healing tissue) superficial (top layer of skin only) scant drainage, (small amount of fluid) no odor (no foul smell). Left plantar great toe abrasion (scrape on the bottom of the left big toe) (measuring) 0.7 x 0.7 cm, (about the size of a pencil eraser) (with) 100% granulation (healing tissue) superficial, scant drainage, no odor. Left anterior toe abrasion (scrape on the front of the toe) (measuring) 1 x 1 cm (about the size of small coin) 100% granulation, superficial, scant drainage no odor. Left 2nd toe abrasion (scrape on the second toe) (measuring) 1 x 0.7 cm, (small coin - size) 100% granulation, superficial scant drainage, no odor. Right lateral great toe abrasion (scraped on the outer side of the right big toe) (measuring) 6 x 3 cm, (about 2 1/2 inches long and 1 1/4 inches wide) (with) 100% granulation superficial scant drainage no odor. Scab wound to 3, 4 and 5 right fingers, (dried, crusted wounds) (with) 100% eschar, (thick dead tissue covering the wounds) no drainage no odor. Discoloration to left hip extending to left thigh (deep bruising from bleeding under the skin) 100% dark purple. Tattoos to upper chest (non - injury identifying marks). Right knee abrasion (scraped skin) (measuring) 2 x 2 (about the size of large coin) 100% granulation superficial, no odor scant drainage. Md (Medical Doctor) made aware, orders received orders carried out and noted. During an interview on January 7, 2026, at 8:23 PM, with the leadership management including DON, ADMIN and DCO, the following documents were reviewed: -Baseline Care Plan (included on the VB - Admit/Readmit Data Collection and Baseline - V6), dated January 2, 2026, x. Fall Risk: A: Is the resident at risk for Falls? Yes, . A1. Fall care plan, Focus: the resident is at risk for falls, . Goal: the resident's risk for injury will be minimized through the review date. Interventions (no checks on interventions), confirmed with the DCO. -Fall Risk assessment dated [DATE], at 10:41, reviewed and confirmed with ADMIN, DON and DCO that Resident 175 was a high risk for fall. -PT/OT Evaluations dated January 5, 2026, and January 6, 2026, reviewed and DON, DCO and ADMIN acknowledged Resident 175, was on contact guard assistance related to his medical conditions including CVA, with right side of the body weakness. Parkinsons.-MDS dated [DATE], was reviewed. -Nursing Progress Note Dated January 7, 2025, at 7:25 PM was reviewed (includes the skin assessment) and VB-Nursing / Readmit Data Collection and Data Baseline - V6 Dated January 2, 2026, at 10:38 PM. was reviewed with the DCO. -Change of Condition dated January 7, 2026, at 9:27 AM was reviewed with DON, (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DCO.-Accident / Prevention Policy-Elopement Prevention Policy-Fall Risk Assessment PolicyDuring a concurrent interview and record review on January 7, 2026, at 8:27 PM, with the DON, ADMIN, and DCO, the facility Policies and Procedures (P&P) titled, Incident and Accident Policy, undated, was reviewed. The P&P indicated, . to ensure the safety, dignity and independence of residents while preventing responding to, and documenting incidents and accidents particularly for resident who require assistance with Activities of Daily Living (ADLs). DON, ADMIN, and DCO acknowledged the policy and stated it was not followed by their staff.During a concurrent interview and record review on January 7, 2026, at 8:31 PM, with the DON, ADMIN and DCO, the facility Policies and Procedures (P&P) titled, Elopement Prevention and Resident Decision - Making, undated, was reviewed. The P&P indicated, To prevent unsafe elopement while protecting the rights of alert resident who possess decision making capacity and the ability to exercise free regarding community access. Scope Applies to all residents and staff involved in resident assessment, supervision, and safety. Elopement is defined as: A resident who is cognitively impaired., leaves the facility unsafely or unknowingly, placing themselves at risk for serious harm. DCO stated Resident 175 was not at risk for elopement and acknowledged the policy applies to all residents.An Immediate Jeopardy (IJ-as a situation that has caused or is likely to cause serious injury, harm, impairment, or death to a resident) was called under F689 S483.25(d)(2) which requires that each resident receive adequate supervision and assistance devices to prevent accidents) on January 7, 2026, at 9:16 PM, in the presence of the Director of Nursing (DON), the Administrator (ADMIN), and the Director of Clinical Operations (DCO). After reviewing observations, interviews and record reviews, it was determined that Resident 175 did not receive the supervision and monitoring required to maintain his safety and prevent elopement, when he left the facility unsupervised at approximately 7:30 AM of January 7, 2026. Resident 175 was later found by law enforcement approximately one mile from the facility and then transported him to the acute care hospital. An Immediate Jeopardy removal plan was requested.An IJ Removal Plan (a plan which includes interventions to remove the potential or actual harm of an immediate jeopardy situation) was reviewed and accepted on January 8, 2026, at 1:30 PM, which included the following: 1. IMMEDIATE ACTIONS TAKEN TO REMOVE THE JEOPARDYThe facility implemented the following actions immediately upon identification of theImmediate Jeopardy to ensure resident safety:Resident 175 was found outside of the facility by [name of the police department] and immediately transported to the acute care hospital via ambulance on 1/7/26 as directed by them for further evaluation and treatment. Resident 175 was readmitted back to the facility same day on 1/7/26 with plan of care updated by the IDT.After readmission to the facility from the acute hospital on 1/7/26, Resident 175 was placed on every hour visual monitoring by nursing staff that started on 1/7/26.A fall risk assessment was completed by the RN ADON on 1/7/26. Resident 175's plan of care is updated on 1/7/26 to address resident's risk for elopement.A Wander/Elopement Risk Evaluation was completed by the RN ADON on 1/7/26.Resident 175's plan of care is updated on 1/7/26 to address resident's risk for elopement.The DOR conducted a Rehab Post Fall Screen on 1/7/26 to continue PT, OT and ST program.Resident 175's individualized care plan was immediately updated on 1/7/26 to reflect:Staff to provide contact guard assist with transfers and utilize use of front wheel walker or wheelchair for ambulationStaff started on every hour visual check Environmental safety interventions were implemented immediately upon readmission on [DATE], including:Bed maintained in the lowest position while Resident 175 is on bedNon-skid footwear appliedCall light applied within reachThe resident's physician and facility's Medical Director, Dr. Sepehr Golboo, was informed of the resident's readmission on [DATE] at 6:57 PM and agreed with the treatment plan.These actions were completed immediately and verified to ensure the resident was no longer at risk for serious harm. 2. SYSTEMIC CHANGES IMPLEMENTED TO PREVENT RECURRENCETo address systemic issues and prevent recurrence, the facility implemented the followingactions:The DON, ADON, MDS Nurse, RNs and LVNs conducted a facility-wide audit to identify all residents at risk for falls on 1/7/26 to 1/8/26. A total of 112 residents at high-risk for falls; Care plans were verified to address the risk for fall.The DON, (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ADON, MDS Nurse, RNs and LVNs conducted a facility-wide audit to identify all residents at risk for elopement on 1/7/26 to 1/8/26. A total of 6 residents at high risk for elopement; Care plans were verified to address the risk for elopement. RN Supervisors to conduct head count of residents during shift-to-shift endorsements to identify any missing residents. Maintenance supervisor or designee to check emergency exit doors alarm system installed in each exit door daily for proper functioning and document result in the emergency exit door alarm check log. When an emergency exit door alarm is activated, facility staff must immediately inspect the door, determine the cause of the alarm, and address the issue. The RN Supervisor, or designee, shall verify that the exit door is fully secured and that the alarm system remains engaged and operational. When a resident is found right outside the emergency exit alarmed door, the facility staff must redirect the resident to get back in. 3. STAFF EDUCATION AND TRAINING On 1/7/26, The Director of Staff Development immediately started providing in-services and education to All direct care staff to be completed on 1/8/26 regarding the following: - o Fall Prevention and Management - o Safety and Supervision of the Resident - o Identifying Change of Condition Occurrence & Reporting - o Charting/Documentation 4. MONITORING TO ENSURE ONGOING COMPLIANCE All fall and elopement incidents and near-misses are reviewed daily by IDT. The Director of Nursing or Designee will conduct weekly audits of fall and elopement incidents for 30 days, followed by monthly audits thereafter. As an additional safety measure, the facility will install an enhanced security system to further ensure resident safety. While awaiting installation, staff will be assigned on a rotational basis to provide continuous monitoring of the front entry door to ensure close supervision of resident movement. The Maintenance Supervisor will be responsible for installing a door alarm on the front entry door. The alarm will be activated in conjunction with the locking of the front entry door during secured hours, defined as 8:00 PM to 5:00 AM. The RN Supervisor will be responsible for verifying that the front entry door is properly locked and the alarm activated at the designated times and for ongoing oversight to ensure compliance. The facility will review with QAPI committee any elopement or reportable missing person occurrence report for the month for review or recommendation to follow up on. The NHA or designee will be responsible to follow up on any recommendations. 5. RESPONSIBLE PARTIES Administrator / Executive Director Director of Nursing Charge Nurses and Supervisors Direct Care Staff The acceptable IJ removal plan was verified with the facility to be implemented through observations, interviews and record review. The IJ was removed on January 8, 2026, at 8:40 PM, in the presence of DON, ADMIN, and DCO.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure residents were provided with a dignified dining experience for two of six sampled residents (Resident 94 and 185) when Certified Nursing Assistants (CNA 1, 2, and 4) were standing over residents while assisting them to eat. This failure has the potential to cause Residents 94 and 185 to feel disrespected and negatively affect their psychosocial well-being and individuality. 1. During a review of Resident 94's clinical records, the admission Record (a document that gives a summary of resident information) indicated, Resident 94 was admitted to the facility on [DATE], with diagnoses which included, dysphagia (difficulty swallowing), hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side (one side of the body is paralyzed or weak, often due to a stroke affecting the opposite brain side, impacting movement, balance, and coordination). During a concurrent observation and interview on January 05, 2026, at 1:03 PM in Resident 94's room, Resident 94 was lying on bed awake. CNA 4 brought the lunch tray and placed it at Resident 94's bedside table. CNA 4 proceeded to assist Resident 94 with lunch. CNA 4 was standing over Resident 94 and stated there was no chair available so she (CNA 4) can feed Resident 94 standing up. CNA 4 did not go out of the room to look for available chair During a concurrent interview and record review on January 6, 2026, at 1:34 PM, with the Director of nursing (DON), the DON reviewed the facility policy and procedure (P&P) titled, [name of the facility] Resident Rights Policy & Procedure undated. The P&P indicated, .Policy: [name of the facility] is committed to protecting and promoting the rights of all residents in accordance with CMS regulations (42 CFR 483.10) and California Title 22. Residents are treated with dignity, respect and individuality and are supported in exercising the rights while residing at the facility. Procedure. 1. b Care is provided in a manner that maintains privacy, dignity, and individuality. The DON acknowledged the policy and stated CNAs can feed standing up if the bed is up and the resident's head elevated. The DON further stated, usually we don't put chairs in resident's room. 2. During a review of Resident's 185 admission Record (clinical record with demographic information), the admission record indicated Resident's 185 was admitted on [DATE], with diagnoses that included epilepsy (a chronic brain disorder) and cerebral infarction (the death of brain tissue due to a sudden blockage of a blood vessel). During a concurrent observation and interview on January 5, 2026, at 12:40 PM, with a Certified Nursing Assistant (CNA 1) in Resident 185's room, CNA 1 raised Resident 185's bed to his waist level, positioned himself next to the resident, placed the bedside table in front of the resident, and proceeded to feed the resident while standing. CNA 1 stated, I normally stand while feeding residents, but it is not right, and I am not supposed to be standing while feeding. During a concurrent observation and interview on January 6, 2026, at 8:29 AM, with CNA 2 in Resident 185's room, Resident 185 bed was in the low position while CNA 2 was standing next to the resident, feeding her. CNA 2 acknowledged and stated she should not be standing while feeding residents. During a concurrent observation and interview on January 6, 2026, at 8:35 AM, with a Licensed Vocation Nurse (LVN 4) in Resident 185's room, LVN 4 raised the bed and stated CNA 2 should not be standing when feeding a resident and should be sitting to promote respect and dignity. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on January 7, 2026, at 8:08 AM with the Director of Nursing (DON), the facility policy and procedure (P&P), titled, [name of facility] Resident's Right Policy and Procedure, undated, was reviewed. The P&P indicated, .Policy: [name of facility] is committed to protecting and promoting the rights of all residents in accordance with CMS regulations (42 CFR 483.10) and California Title 22. Residents are treated with dignity, respect and individuality and are supported in exercising the rights while residing at the facility. Procedure .1. Rights Dignity, Respect and Quality of Life.a. Residents are treated with courtesy, consideration, and respect at all times.b. Care is provided in a manner that maintain privacy, dignity, and individuality. The DON acknowledged the policy was not followed and further stated it should have been.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure confidentiality of resident's Electronic Health Records (EHR- medical records kept on a computer system) when a Licensed Vocational Nurse (LVN 7) left Resident 96's health information on the computer screen, unattended and visible to the public in the hallway. This failure had the potential to place Resident 96's private information to be at risk of being disclosed by an unauthorized person. During a review of Resident 96's admission Record (contains demographic and medical information), it indicated Resident 96 was admitted to the facility on [DATE], with diagnoses which included peripheral venous insufficiency (a circulation problem where veins, usually in the legs, struggle to send oxygen-poor blood back to the heart), congestive heart failure (the heart muscle cannot pump blood efficiently) and urinary tract infection (bacterial infection in any part of your urinary system). During a concurrent observation and interview on January 7, 2026, at 5:36 AM, with LVN 7, LVN 7 went inside Resident 96's room to administer medication. The computer screen was left open and unattended on the medication cart, in the hallway in Wing A, with Resident 96's name, picture, medication administration record, vital signs and weight available for anyone to view. LVN 7 acknowledged and verified the private health information presented on the unattended screen. When asked who is responsible for keeping resident information confidential, LVN 7 stated that it is not my responsibility for something, someone else sees. During a concurrent interview and record review on January 7, 2026, at 12:42 PM, with Director of Nursing (DON), the facility's policy and procedure (P&P) titled, [name of the facility] Computer Privacy Screen Policy, dated January 14, 2025, was reviewed. The P&P indicated, Guidelines. Staff must log off or lock computers when unattended. The DON stated that the policy was not followed and his expectation is for the staff to maintain resident's privacy.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the care plan (a personalized, written document that details an individual's health conditions, specific needs, goals, preferences, and the support required to achieve them) for two of ## sampled residents (Residents 162 and 23) was developed and implemented when: Resident 161 did not have a care plan allowing medication at his bedside. Resident 23 did not have a care plan for smoking. These failures had the potential for Resident 161 and Resident 23 to be at risk of injury, due to delayed intervention and supervision. 1. During a review of Resident 161 admission Record (clinical record with demographic information), the admission Record indicated, Resident 161 was admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a progressive lung condition that makes breathing difficult), hypertensive heart disease (heart problems caused by long-term high blood pressure), and acute kidney failure (sudden inability of the kidneys to filter waste and balance fluids). During a concurrent observation and interview on January 5, 2026, at 9:36 AM, with a Licensed Vocational Nurse (LVN 5), in Resident 161's room, Resident 161 was sitting on his bed with a bottle of Tums Oral Tablet Chewable (medication used to quickly relieve heartburn, acid indigestion, sour stomach, and upset stomach) at bedside. LVN 5 stated the Tums should not be kept at bedside. A continued interview on January 5, 2026, at 9:40 AM, with LVN 5, LVN 5 stated there is no care plan developed to keep medication at bedside for Resident's 161. During a review of Resident's 161's physicians' orders, dated December 18, 2024, it indicated, Tums Oral Tablet Chewable. Give 500 mg (milligram a unit of measurement for medication dosages) by mouth every 12 hours as needed for GERD (Gastroesophageal Reflux Disease- chronic digestive disorder where stomach acid frequently flows back into the esophagus, causing symptoms like heartburn) give 2 tablets. During a concurrent interview and record review on January 7, 2026, at 8:15 AM with the Director of Nursing (DON), the facility policy and procedure (P&P), titled, Medication Storage and Labeling Policy & Procedure (Title 22), undated, was reviewed. The P&P indicated, .1. General Storage Requirements.c. Access to medications is limited to authorized licensed personnel only. The DON acknowledged the policy was not followed and a care plan should have been created. 2. During a review of Resident 23's admission Record, the admission Record indicated, Resident 23 was admitted on [DATE], with diagnoses that included T2DM (diabetes mellitus 2 - when the body does not produce enough insulin), chronic kidney disease (gradual loss of kidney function where damaged kidneys cannot properly filter waste and fluid from the blood) and hypertension (high blood pressure). During a concurrent observation and interview on January 5, 2026, at 10:45 AM, with Resident 23, in Resident 23's room, Resident's 23 was sitting on his bed. Resident 23 stated he smokes outside, at the designated area, and gets his cigarette from nurses on duty. During a concurrent observation and interview on January 6, 2026, at 2:00 PM, with Activities Specialist (AS 1) and the Activity Director (AD), Resident 23 was observed outside the Activities' room smoking unsupervised. AS 1 confirmed that Resident 23 had been smoking outside unsupervised. AD stated she was not aware there was no care plan for Resident 23 for unsupervised smoking. During a concurrent interview and record review on January 6, 2026, at 4:37 PM, with the MDS Director (Resident Assessment Coordinator- who oversees the federally mandated assessment process for nursing home residents, ensuring accurate documentation for care planning), the MDS Director stated during the admission assessment, Resident 23 denied that he is a smoker. The MDS Director further stated Resident 23 should have been re-assessed, and a care plan should have been created. During a concurrent interview and record review on January 7, 2026, at 8:15 AM, with the Director of Nursing (DON), the facility policy and procedure (P&P) titled, Rialto Post Acute Smoking and Tobacco Use Policy & Procedure, undated, indicated, .8. Documentation and Care Planning. Smoking status and safety assessments are documented. Supervision requirements and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restrictions are included in the resident's care plan. The DON acknowledged the policy was not followed and a care plan should have been created.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to maintain accurate records of controlled medications (medications that are controlled by government due to potential abuse or addiction) for one of six sampled medication carts (Medication Cart A-1) with narcotics when the Narcotic Count Sheet (a narcotic log used by the facility to verify counting of controlled medications at the change of shift, signed by the incoming and outgoing licensed nurses) had one missing signature for the outgoing licensed nurse on January 2, 2026. This failure had the potential to result in drug diversion (illegally obtaining or using prescription drugs), undetected medication discrepancies, or medication errors which could compromise the health and safety for the vulnerable population of 159 residents. During a concurrent observation and interview on January 6, 2026, at 9:58 AM with a Licensed Vocational Nurse (LVN 8), in Wing A at Medication Cart A-1, the Narcotic Count Sheet for January 2026, was reviewed. The Narcotic Count Sheet had one missing signature for nurse 1 (the outgoing nurse), on January 2, 2026, night shift. LVN 8 verified the missing signature and further stated the log should have been signed by two LVNs verifying the correct number of narcotics in the medication cart. During a concurrent interview and record review on January 6, 2026, at 2:06 PM with the Director of Staff Development (DSD), the facility's policy and procedure (P&P) titled, [name of the facility] Controlled Substances (Narcotic) Signing Policy & Procedure, dated January 14, 2025, was reviewed. The P&P indicated, . 5. Shift- to- Shift Count. a. Controlled substances are counted and reconciled at every shift change. b. two licensed nurses perform the count and verify accuracy. The DSD stated that the P&P was not followed. The DSD further stated the counts should have been verified by both nurses, and a missing signature could indicate an incorrect count or missing narcotic and should have been reported to the Director of Nursing (DON). During a concurrent interview and record review on January 7, 2026, at 12:45 PM, with DON, the facility's P&P titled, [name of the facility] Controlled Substances (Narcotic) Signing Policy & Procedure, dated January 14, 2025, was reviewed. The P&P, indicated, . 5. Shift- to- Shift Count a. Controlled substances are counted and reconciled at every shift change. b. two licensed nurses perform the count and verify accuracy. The DON stated that the policy was not followed.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure storage of medications were properly secured for one of 12 medication carts (Medication Cart A-1) when one Licensed Vocational Nurse (LVN 7) left the medication cart keys, on top of the medication cart, unattended in the hallway in Wing A. This failure had the potential to result in unauthorized access to medications, including controlled substances, which could result in medication diversion (illegally obtaining or using prescription drugs), unauthorized access, misuse, and harm to a highly vulnerable population of 159 residents. During record review of Resident 96's admission Record (contains demographic and medical information), it indicated Resident 96 was admitted to the facility on [DATE], with diagnoses which included peripheral venous insufficiency (a circulation problem where veins, usually in the legs, struggle to send oxygen-poor blood back to the heart), congestive heart failure (the heart muscle can't pump blood efficiently enough to meet the body's needs, causing fluid to back up in the lungs, legs, and other tissues) and urinary tract infection (bacterial infection in any part of your urinary system). During a concurrent observation and interview on January 7, 2026, at 5:25 AM, with LVN 7, LVN 7 was in the hallway in Wing A preparing medication, LVN 7 then proceeded to go inside Resident 96's room to discuss medication. The medication keys used to unlock Medication Cart A-1 were left on top of the medication cart unattended, outside Resident 96's room. LVN 7 verified the keys left on top of Medication Cart A-1 were the keys to open that medication cart LVN 7 further stated, The keys should not be left unattended but are left inside the binder on the cart so other LVNs can open the cart if they need to. During a concurrent interview and record review on January 7, 2026, at 12:38PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, [name of the facility] Medication Cart Key Control Policy, dated January 14, 2025, was reviewed. The P&P indicated, Key Control Guidelines. Each medication cart key must remain with the assigned staff member at all times. Keys must never be left unattended, including on carts, desks, or in the drawers. The DON stated the policy was not followed. The DON further stated it was important for staff to store the keys on them to prevent unassigned personnel from gaining access to the medications.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a physician-ordered therapeutic diet was provided for one of six sampled resident (Resident 7), when nutritional supplements (Health shake and Sherbert) listed on the meal ticket were omitted in the lunch tray. This failure had potential to place Resident 7 at risk for weight loss and nutritional decline. During a review of Resident 7's admission Record (a document that gives a summary of resident information), the admission Record indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which included, type 2 diabetes mellitus with hyperglycemia (blood sugar levels are consistently too high due to the body's inability to use insulin effectively (insulin resistance)), essential hypertension (high blood pressure with no single, identifiable medical cause) and anemia (a condition where your blood lacks enough healthy red blood cells). During a concurrent observation and interview on January 05, 2026, at 12:30 PM, in Resident 7's room, Certified Nursing Assistance (CNA 3) served lunch tray. The lunch meal ticket for Resident 7, dated January 5, 2026, indicated, Tray Instructions: 4 oz (ounce) Health shake and sherbert ice cream. CNA 3 stated health shake and ice cream were not served; and it did not come from the kitchen. Resident 7 stated, she did not receive health shake or Ice cream. CNA 3 further stated, I did not know she gets it every day. During observation on January 5, 2026, at 12:50 PM, CNA 3 removed Resident 7's lunch tray out of the room. During record review reviewed Resident 7 physician's order, dated November 14, 2025, indicated Health Shake three times a day for weight management 4 oz with meals, Sherbert BID (two times) (lunch/Dinner two times a day for weight. During a concurrent interview and record review on January 6, 2026, at 3:02 PM, with Director of Dining (DD), Dietician Consultant (DC) and DON reviewed the facility's policy and procedure (P&P) titled, [name of the facility] Physician Order policy & Procedure, undated. The P&P indicated, .4. Implementation of Orders, a. Orders are implemented promptly and carried out exactly as prescribed. The DD stated staff should have followed what is on the meal ticket. The DC stated the kitchen staff should serve what was ordered by the doctor.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper and safe infection control practices were followed when: One Certified Nursing Assistant (CNA 6) entered Resident 184's room, without performing hand hygiene and used the same gloves after emptying Residents 67's urinal (portable container, often bottle-shaped used to collect urine for urination) to turn off the call light, Resident 184's intravenous catheter (IV- a small, flexible plastic tube that a healthcare provider puts into a vein to deliver fluids, medicine, nutrition, or blood directly into the bloodstream) on the left wrist was found unlabeled. Resident 89's gastrostomy tube (g-tube- a feeding tube placed through the abdomen directly into the stomach, used to deliver nutrition, fluids, and medicine) water bag (a bag used to hold and deliver water through the g-tube) was found hanging more than 24 hours (per manufacturer's instructions to be discarded after 24 hours). These failures had the potential to result in cross-contamination (spreading harmful bacteria and germs from one person, surface, or object to another) causing a preventable infection to 159 highly vulnerable residents whose health conditions were already compromised. 1. During a review of Resident 67's admission Record (contains demographic and medical information), it indicated Resident 67 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (a common infection caused by germs, usually bacteria, getting into any part of your urinary system and multiplying), and Extended Spectrum Beta Lactamase (ESBL) resistance (bacteria that is resistant to some antibiotics, making the infections harder to treat). During a review of Resident 184's admission Record, it indicated Resident 184 was admitted on [DATE], with diagnoses which included systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction (inflammation throughout the entire body, without damage to major organs) and abnormalities of gait and mobility (deviation from a normal, smooth, and efficient walking pattern). During a concurrent observation an interview on January 6, 2026, at 10:49 AM, with CNA 6, CNA 6 was emptying out Resident 67's urinal with both hands, into a shared restroom. CNA 6 proceeded to walk behind the privacy curtain in Residents 184's room, holding Residents 67's urinal in her right hand, wearing the same gloves. CNA 6 proceeded to turn off the mounted wall call light (a nurse call button) in Resident 184's room with her left hand, opened the privacy curtain (used to divide the room) with the same gloves, and then return to Resident 67's urinal at his bedside. CNA 6 acknowledged and stated she should have returned Resident 67's urinal, removed gloves, and performed hand hygiene before answering Resident 184's call light. CNA 6 further stated the infection control process was not followed when handling Resident 67's urinal, placing the residents at risk for cross-contamination. During a concurrent interview and record review on January 7, 2026, at 12:49 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, [name of the facility] ADL Provision Policy & Procedure (Including Emptying of Urinals), dated January 14, 2025, was reviewed. The P&P indicated, .emptying of urinals, is provided in accordance with infection control standards. 3. Use and Emptying of Urinals. b. Urinals are emptied promptly into designated toilets or hoppers only. f. Hand hygiene is performed immediately after task completion. 4. Infection Prevention During ADLs. a. Hand hygiene is performed before and after resident contact. The DON stated the P&P was not followed. The DON further stated the CNA should have disinfected her hands before helping the other residents for infection control. 2. During a review of Resident 184's admission Record, it indicated Resident 184 was admitted on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], with diagnoses which included systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction (inflammation throughout the entire body, without damage to major organs) and abnormalities of gait and mobility (deviation from a normal, smooth, and efficient walking pattern). During a concurrent observation and interview on January 6, 2026, at 11:02 AM, with License Vocational Nurse (LVN 1), in Resident 184's room, Resident 184's IV label was found undated. LVN 1 verified that there was no date, time of insertion, or staff initials labeled on the dressing. LVN 1 further stated that IV should be labeled, and it was the Registered Nurse's (RN) responsibility to ensure the IV dressing is labeled. During a subsequent observation and interview on January 6, 2026, at 11:03 AM, with the RN 2, in Resident 184's room, Resident 184's IV dressing was checked. The RN 2 verified Resident 184's IV dressing was unlabeled. During a concurrent interview and record review on January 7, 2026, at 1:03 PM, with the DON, the facility's &P titled, [name of the facility] IV Care and Maintenance Policy & Procedure, dated January 14, 2025, was reviewed. The P&P indicated .3. Dressing & Tubing Management a. IV dressings are clean, dry, intact, and dated. The DON stated the policy was not followed, and further stated that all IVs should be labeled, no exceptions. 3. During a review of Resident 89's admission Record (clinical record with demographic information), the admission Record indicated, Resident 89 was admitted on [DATE], with diagnoses that included hemiplegia (paralysis affecting one side of the body) and hemiparesis (weakness on one side of the body, affecting the arm, leg, or face, often resulting from brain injury) and type 2 diabetes mellitus (T2 DM - a chronic condition where the body either does not produce enough insulin) and gastrotomy tube (G-tube - a soft tube placed through the belly wall directly into the stomach, creating a shortcut to deliver food, liquids, and medicine). During a review of Resident's 89's physicians' orders, dated December 18, 2024, it indicated an order for, Enteral Feeding Order every shift for tube feeding Fibersource HN (nutritionally complete, high-protein, fiber-rich liquid formula for tube feeding) 1.2 Kcal (Kilocalories- unit of energy) running at 85 ml (milliliter - unit of volume)/hr (hour) for 20 hrs to provide 1700 ml/2040 Kcal via enteral pump (a medical device that accurately delivers liquid nutrition directly into a patient's stomach). Enteral Feed Order: every shift water flush via [brand name] pump (a device used for enteral feeding, delivering liquid nutrition (and sometimes hydration/thick formulas) directly into a patient's stomach) 40 ml every hour x (times) 20 hours to complete 800 ml QD (once a day) via G-tube, for hydration. During an observation on January 5, 2026, at 10:00 AM, in Resident's 89's room, Resident 89 was lying in bed, awake, with the head of the bed slightly elevated. Resident 89 was connected to a feeding pump that was turned off. There was an enteral formula [brand of formula] bag labeled with a date of January 4, 2026, at 2100 (9:00 PM) and a hydration bag containing water hanging on the pole next to Resident 89's bed, the water bag was dated January 3, 2026 (approximately 37 hours expired), at 21:40 (9:40 PM). During a concurrent observation and interview on January 5, 2026, at 10:19 AM, with the License Vocational Nurse (LVN 5) in Resident 89's room, LVN 5 stated the enteral formula, and the water hydration bags were hung by the previous nurse. LVN 5 verified the water bag was dated January 3, 2026 (1 day and 13 hours expired). LVN 5 further stated the water bag should not be used for more (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
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 01/08/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than 24 hours as indicated in the manufacturer instruction on the bag. During a review of [brand name] water flush bag 1000 ml (a separate bag) manufacturer's instruction, it indicated, The feeding set (bag and tubing, including the flush bag) itself must be replaced every 24 hours. During an interview on January 7, 2026, at 8:05 AM, with the Director of Nursing (DON), the DON stated that the facility does not have a policy specifying the required hang time for G-tube water bags, but nurses should follow the doctor's orders and the manufacturer's instructions. The DON acknowledge that the manufacturer's instruction was not followed.		

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 01/08/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure call light (a device that allows patients to communicate with nursing staff when they need assistance) was within reach for two of 32 sampled residents (Resident 24 and 120). This failure had the potential to place Residents 24 and 120 at risk of harm when they are unable to summon staff during an emergency or when needing assistance. 1. During a review of Resident 120's admission Records (a document that gives a summary of resident information), the admission Records indicated, Resident 120 was admitted to the facility on [DATE], with diagnoses which included, end stage renal disease, (chronic kidney disease where kidneys lose almost all function) and history of falling. During a concurrent observation and interview on January 05, 2026, at 11:23 AM, in Resident 120's room, Resident 120 was lying on bed awake. The call light was not located on the bed. Resident 120 stated she did not know where the call light was. Resident 120 looked around the top and under the bed cover but was unable to locate the call light device. Certified Nursing Assistant (CNA 5) was at bedside and looked for the call light device on Resident 120's bed and was unable to find it. CNA 5 stated, she was not sure where the call light device was. CNA 5 then continued to look for the call light and found it on top of Resident 120's roommate oxygen tank. CNA 5 picked up the call light and placed it on resident 120's bed and stated the call light should be on the resident's bed. During concurrent interview and record review on January 6, 2026, at 8:51 AM, with the Director of nursing (DON), the DON reviewed the facility policy and procedure (P&P) titled [name of the facility] Call Light Policy and procedure, undated. The P&P indicated, . 1 Call lights are placed within reach of the resident at all times including after care, repositioning, or transfers. The DON stated the expectation is for all the staff to ensure the call lights are within easy reach of the residents. The DON acknowledged and stated that the policy was not followed. 2. During a review of Resident 24 admission Record clinical record with demographic information), the admission record indicated, Resident 24 was admitted on [DATE], with diagnoses that included bilateral primary osteoarthritis (a degenerative joint disease where protective cartilage wears down, causing bones to rub, leading to pain, stiffness, swelling, and reduced mobility), hypertension (high blood pressure) and depression (serious mood disorder causing persistent sadness, loss of interest, and impacting daily life). During a concurrent observation and interview on January 5, 2026, at 4:05 PM, in Resident's 24 's room, Resident 24 was sitting at the edge of the foot of the bed. Resident 24 was crying and stated she needed assistance to go out of the room, but she could not find her call light. Resident 24's call light was located on the head of the bed and placed under a pillow. During an interview on January 5, 2026, at 4:10 PM, with a License Vocational Nurse (LVN 2), LVN 2 stated the call light must be within resident's reach and should be accessible to them. During a concurrent interview and record review on January 7, 2026, at 7:50A M, with the Director of Nursing (DON), the facility policy and procedure (P&P), titled Call light Policy and Procedures, undated, indicated, .1. Call lights are placed within reach of the resident at all times, including after care, repositioning, or transfers. DON acknowledged the policy was not followed and should have been.		