STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055409	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care and Rehabilitation Center	4070 Jurupa Avenue Riverside, CA 92506

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 - 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four residents reviewed (Resident 1) was monitored and supervised to prevent a fall. This failure had the potential to cause injury and harm to Resident 1.Findings: On August 21, 25, 26, 27, and 28, 2025, on-site visits at the facility were conducted to investigate a complaint regarding quality of care. On August 25, 2025, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included fall, subdural hemorrhage (a pool of blood between the brain and its covering), urinary tract infection (UTI - an infection in the urinary tract), malignant neoplasm of the colon (cancer of the large intestine), and dementia (memory loss). A review of Resident 1's fall risk assessment dated [DATE], indicated a score of 15 (at risk for falls). A review of Resident 1's history and physical dated April 3, 2025, indicated Resident 1 did not have the capacity to make medical decisions. It also indicated Resident 1 was confused. A review of Resident 1's progress notes dated April 3, 2025, at 2:56 a.m., indicated a Certified Nursing Assistant (CNA) noted Resident 1's room door was closed. The CNA entered Resident 1's room and Resident 1 was found on the floor lying on her right side and watching the television. The 72 hour neuro check (a neurological assessment to evaluate potential brain or spinal cord injuries) post fall was initiated. A review of Resident 1's progress notes dated April 3, 2025, at 11: 10 a.m., indicated Resident 1 needed frequent monitoring due to poor safety awareness. A review of the progress notes dated April 3, 2025, at 8:40 p.m., indicated Resident 1's bed was in lowest position. Resident 1 crawled to the floor and started to scream and yell. Resident 1 was very agitated. A review of the progress notes dated April 3, 2025, at 11:06 p.m., indicated the CNA saw Resident 1 crawl out of the bed again and was put back in bed by the CNA. A review of Resident 1's change of condition, dated April 4, 2025, at 4:10 a.m., indicated, The Change in Condition/s reported.Falls.Mental Status Evaluation.No changes observed. Nursing observations, evaluation, and recommendations are.Resident extremely confused. There was no documented evidence Resident 1 was visually checked or monitored from April 3, 2025, at 11:06 p.m. to April 4, 2025, at 4:10 a.m., after Resident 1 was observed crawling out of bed twice before she had a fall. A review of Resident 1's care plan dated April 3, 2025, indicated, The resident is at risk for falls r/t (related to) Confusion.Interventions.Follow facility fall protocol.PROVIDE C NA (sic) AT BEDSIDE WHEN WAKEFUL OR AGITATED.Q1hour (every one hour) checks for increased super vision (sic). On August 26, 2025, at 9:57 a.m., during a concurrent interview and record with the Quality Assurance Nurse (QAN), she stated fall interventions included bed in lowest position, call light within the resident's reach, use of non-skid socks and frequent visual monitoring. The QAN stated Resident 1's care plan indicated Q1hr checks for increased supervision. She stated the care plan for Resident 1should have been followed. On August 26, 2025, at 11:09 a.m., a concurrent interview and record review was conducted with the Registered Nurse (RN). The RN stated Resident 1 was a high risk for fall based on the Fall Risk Assessment on April 2, 2025. The RN stated that when a resident was high risk for falls, the resident should been seen frequently to ensure safety. She also stated a care plan for fall should be developed and interventions should be followed. The RN stated Resident 1's care plan indicated she should have been seen every one hour for increased supervision. On August 27, 2025, at 8:33 a.m., a concurrent interview and record review was conducted with the Licensed Vocational Nurse (LVN). The LVN stated she worked the night of April 3, 2025, and was assigned to Resident 1. The LVN stated a CNA reported to her Resident 1 was on the floor. The LVN could not recall who the CNA was that reported to her. The LVN stated if the resident was a fall risk, the resident should have been checked frequently. The LVN stated Resident 1's care plan indicated Q1 hour monitoring for supervision. The LVN stated she did not have the time to do frequent visual checks on Resident 1. On August 28, 2025, at 1:45 p.m., during an interview with the Director of Nursing (DON), he stated when a resident was a fall risk, frequent visual checks should have been done. A review of the facility policy and procedure titled Fall Prevention Program, revised December 28, 2023, indicated, .Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level.The event may be.presumed when a resident is found on the floor or ground. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk.The nurse and/or interdisciplinary team will initiate interventions on the resident's care plan, in accordance with the resident's level of risk.At Risk Protocols Provide additional