

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056162	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/04/2025
NAME OF PROVIDER OR SUPPLIER  Extended Care Hospital of Riverside		STREET ADDRESS, CITY, STATE, ZIP CODE  8171 Magnolia Avenue Riverside, CA 92504	

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 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.  (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

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the physician was notified of a significant change in condition and refusal of treatment for one of seven sampled residents (Resident 1). This failure had the potential for further confusion, aggressive behaviors, and refusal of care, and led to discomfort with the potential for complications related to untreated infection. Findings: On July 10, 2025, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses including toxic encephalopathy (a condition of chemical imbalance in the blood) and urinary tract infection (UTI - an infection that occurs in any part of the urinary system [how the body gets rid of extra water and waste]). A review of Resident 1's Care Plan dated March 26, 2025, indicated, .the resident has impaired immunity .the resident will remain free from infection through the review date.the resident will not display any complications related to immune deficiency .interventions.monitor/document/report to MD s/sx of delirium: change in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness, and agitation, altered sleep cycle. A review of facility document dated June 13, 2025, indicated, .Patient (Resident 1) is irritable, no distress noted. At baseline mentation. A review of Resident 1's Physician Order dated, June 13, 2025, indicated, .U/A (urinalysis) with C/S (culture and sensitivity - a laboratory test to identify the type of bacteria causing an infection and to determine which antibiotics treatment) for routine lab on Monday AM June 16, 2025. A review of Resident 1's Progress Notes, indicated, -Dated June 13, 2025, at 9:54 p.m., .Dr.new order for UA with C/S on Monday AM.June 16, 2025 .for routine lab.resident aware noted and carried out. -Dated June 16, 2025, at 2:27 p.m., .patient (Resident 1) refused meds and blood sugar checks this shift.she yelled and attempted hitting at nurse.resident refused to be changed.yelled at nurse when talked to her.patient yelled and tried hitting at nurse.pt was left alone.will endorse to next shift continue to monitor. - Dated June 20, 2025, at 8:00 a.m., .patient (Resident 1) behavior still not cooperative and refusing meds, treatments, meals, and even supplements ordered and given.also refusing to work with RNA (restorative nursing assistant).MD (Physician) made aware of residents behavior worsening.awaiting call from MD. - Dated June 20, 2025, at 4:23 p.m. indicated, .NP (nurse practitioner) came to visit resident.resident observed to be noncompliant with care.MD ordered to have the resident sent out to hospital for further evaluation including doing the urinalysis as the resident refused to have urine collected last time for UA test. -Dated June 26, 2025, at 10:55 p.m. indicated, .readmit patient from (name of hospital) with DX (diagnosis) of UTI.incontinent of bowel and bladder. Further review of Resident 1's progress note indicated no documentation that the physician was notified of the resident's behavior changes and refusal to complete the ordered urinalysis on June 16, 2025. Physician notification did not occur until June 20, 2025 (four days after the change in condition). On July 10, 2025, at 1:16 p.m., an interview and record review of Resident 1's progress notes were conducted with LVN 1. LVN 1 stated Resident 1 refused urine collection and had a change in behavior on June 16, 2025. LVN 1 stated, she should have reported Resident 1's refusal and behavior change to the physician. On July 10, 2025, at 1:56 p.m., an interview and record review of Resident 1's progress notes were conducted with Registered Nurse (RN) 1. RN 1 stated the process for treatment refusals was to contact the physician and document in the medical record. RN 1 stated, the physician placed a new order for urinalysis on June 16, 2025. RN 1 stated, the urine sample was not obtained, the refusal should have been documented, and the physician should have been notified. A review of the facility policy titled, Notification of Changes, dated December 2022, indicated, .to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.examples.recurrent episodes of delirium, recurrent UTIs.significant change in the resident's physical, mental or psychosocial conditions such as deterioration in health, mental or psychosocial status.acute condition.exacerbation of a chronic condition.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure care and treatment were provided for four of seven residents reviewed (Residents 1, 4, 5, and 6) when: 1. For Resident 1, the licensed nurses did not timely assess and monitor the resident who experienced a change in condition on June 16, 2025. This failure resulted in the hospitalization of Resident 1 on June 20, 2025, with a diagnosis of urinary tract infection (an infection that occurs in any part of the urinary system [how the body gets rid of extra water and waste]). 2. For Residents 4, 5, and 6, peripheral intravenous (IV - administration of fluids or medication through the vein) sites were not documented as assessed or changed for the duration of the admission. This failure had the potential to place Residents 4, 5, and 6 at risk for infection and injury due to prolonged use of the same IV access. Findings: 1. On July 10, 2025, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses including toxic encephalopathy (a condition of chemical imbalance in the blood) and urinary tract infection. A review of the Care Plan the resident has impaired immunity dated March 26, 2025, indicated, the resident will remain free from infection through the review date. the resident will not display any complications related to immune deficiency. interventions. monitor/document/report to MD s/sx of delirium: change in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness, and agitation, altered sleep cycle. A review of Resident 1's Physician Order dated, June 13, 2025, indicated, .U/A (urinalysis) with C/S (a laboratory test used to identify the type of bacteria causing an infection to determine which antibiotics or treatments) for routine lab on Monday AM June 16, 2025. A review of Resident 1's Progress Notes, indicated, -Dated, June 13, 2025, at 9:54 p.m., .Dr.new order for UA with C/S on Monday AM. June 16, 2025 for routine lab. resident aware noted and carried out. -Dated, June 16, 2025, at 2:27 p.m., .patient (Resident 1) refused meds and blood sugar checks this shift. she yelled and attempted hitting at nurse. resident refused to be changed. yelled at nurse when talked to her. patient yelled and tried hitting at nurse. pt was left alone. will endorse to next shift continue to monitor. - Dated, June 20, 2025, at 8:00 a.m., .patient (Resident 1) behavior still not cooperative and refusing meds, treatments, meals, and even supplements ordered and given. also refusing to work with RNA (restorative nursing assistant). MD (Physician) made aware of residents behavior worsening. awaiting call from MD. - Dated June 20, 2025, at 4:23 p.m. indicated, .NP (nurse practitioner) came to visit resident. resident observed to be noncompliant with care. MD ordered to have the resident sent out to hospital for further evaluation including doing the urinalysis as the resident refused to have urine collected last time for UA test. -Dated June 26, 2025, at 10:55 p.m. indicated, .readmit patient from (name of hospital) with DX (diagnosis) of UTI. incontinent of bowel and bladder. Further review of Resident 1's progress note indicated no documentation that Resident 1's change in behavior was monitored and assessed on June 16, 2025. On July 10, 2025, at 1:16 p.m., an interview and record review of Resident 1's progress notes were conducted with LVN 1. LVN 1 stated on June 13, 2025, she documented that Resident 1 refused to provide a urine sample for laboratory testing to rule out a possible urinary tract infection. LVN 1 stated Resident 1 was combative, refused care, and refused to do the labs (ordered tests) on June 16, 2025. LVN 1 was unable to describe or was unaware of the mental effects a urinary tract infection could cause in at risk female residents. LVN 1 stated, Resident 1 had a change in mental status on June 16, 2025, which she should have reported to the physician. LVN 1 stated she should have monitored the resident and documented in the progress note. On July 10, 2025, at 2:08 p.m., an interview and record review of Resident 1's progress notes from June 5 to June 20, 2025, were conducted with the Director of Nursing (DON). The DON stated, Resident 1 had increased confusion and documented refusals of care on multiple occasions. The DON sated, on June 16, 2025, Resident 1 refused and strike staff and that should have been a change in condition. The DON stated, there was no documentation regarding Resident 1's behavior changes. The DON stated there was a risk of further complications for Residents with an infection and it should have been addressed on June 16, 2025, and the staff should not have waited to communicate the change on June 20, 2025. The DON further stated care plans should be revised and updated with changes in condition so that the interventions in place reflect the current status of the residents. 2a. A review of Resident 4's medical record indicated Resident 4 was admitted to the facility on [DATE], with diagnosis which included, metabolic encephalopathy (chemical imbalance in the blood), and urinary tract infection (UTI). The History and Physical Examination, dated June 11, 2025, indicated Resident 4 has</p>		