STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056162	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Riverside	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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F 0609 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 observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported to the State survey agency within two hours for two of five residents, (Residents 2 and 3).This failure had the potential for a delay in the investigations and interventions to prevent further incidents of abuse. Findings:On December 9, 2025, at 10:14 a.m., an unannounced visit to the facility to investigate an allegation of physical abuse. A review of Resident 2's medical record indicated the resident was admitted on [DATE], with diagnoses of dementia, (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and pressure ulcer injury stage 4 (PUI - full thickness tissue loss with exposed bone, tendon, or muscle).A review of Resident 2's History and Physical dated September 22, 2025, indicated resident was not capable of understanding and making decisions.A review of Resident 3's medical record indicated the resident was admitted on [DATE], with diagnoses of chronic obstructive pulmonary disease, (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), polyneuropathy, (the simultaneous malfunction of many peripheral nerves throughout the body), and depression, (a mood disorder that causes a persistent feeling of sadness and loss of interest).A review of Resident 3's History and Physical dated November 8, 2025, indicated resident had the capacity to make decisions.On December 9, 2025, at 11:52 a.m., during an observation of Resident 2, the resident was lying in bed on his right side, with eyes slightly opened, respirations were even and unlabored. Resident 2 did not respond to verbal questions. On December 9, 2025, at 12:18 p.m., during an interview with the Licensed Vocational Nurse (LVN 1), LVN 1 stated that Resident 2 was occasionally awake and could not be able to get out of bed. LVN 1 stated allegations of abuse should be reported to the Administrator, Director of Nursing within two hours. LVN 1 stated that an allegation of abuse would require keeping residents apart, physician notification, documentation of a change in condition, and care plan updates. On December 9, 2025, at 12:32 p.m., during an interview with Resident 3, Resident 3 stated that back in November 2025, Resident 2 reached toward the television remote and toward his bed, so he flicked Resident 2 on the head. Resident 3 stated there were no witnesses to the event. On December 9, 2025, at 1:01 p.m., during an interview with Licensed Vocational Nurse (LVN 2), LVN 2 stated that if a resident flicked another resident in the head, she would report the incident right away to the Registered Nurse, the abuse coordinator. A review of Resident 3's Progress Notes dated November 23, 2025, at 8 a.m., indicated Resident hit another resident on the head for being too noisy. Client educated on the importance of hitting or coming into contact with another resident. Resident reported he is lucky I didn't kick his ass. Resident again educated. Resident reported he flick the other resident on the head to quiet him. Further review of Resident 3's Progress Notes dated November 23, 2025, indicated no documentation that the alleged incident was reported to the California Department of Public Health (CDPH) within two hours. On December 9, 2025, at 3:01 p.m., during an interview with the Director of Nursing (DON), the DON stated that on December 1, 2025, the Social Service Director notified him of the November 23, 2025, incident at 8 a.m. The DON confirmed that the incident was considered an allegation of physical abuse and should have been reported within two hours to the CDPH. The DON stated that the incident was not reported within the required timeframe.On December 18, 2025, at 12:38 p.m., during a telephone interview with the Social Service Director (SSD), the SSD stated on December 1, 2025, she was reviewing Resident 3's progress notes, and noted the incident on November 23, 2025, at 8 a.m., and notified the DON. The SSD stated that the incident was reported to the state survey agency on December 1, 2025 (seven days after the incident). On December 18, 2025, at 12:51 p.m., during a telephone interview with LVN 3, LVN 3 stated that on November 23, 2025, at 8 a.m., a certified nursing assistant reported that there was an incident with Resident 3 and Resident 2. LVN 3 stated that during an interview with Resident 3, Resident 3 admitted flicking Resident 2 on the head. LVN 3 stated Resident 2 had no injuries from the incident. LVN 3 stated she was not aware that allegations of abuse were required to be reported within two hours. A review of Resident 2's eINTERACT SBAR Summary for Providers dated December 1, 2025, at 12:06 p.m., indicated The Change In Condition/s reported on this CIC Evaluation are/were. Resident's room mate (sic) allegedly flicked his head on 11/23/2025. He is safe with no injuries. No concerns or worries. room mate's (sic) bed moved to another room. MD and family aware. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: - Continue with POC A review of Resident 3's eINTERACT SBAR