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	02/13/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview, and record review, the facility failed to ensure an environment free of accident hazards and to ensure resident receives adequate supervision and assistance devices, for three of three residents reviewed for accidents (Residents 34, 85 and 24) when:1.Resident 34 was found to have cigarettes and a lighter at bedside. This failure had the potential to place Resident 34 and other residents at risk for harm and injuries.2.Resident 85 did not receive adequate supervision and effective fall prevention interventions.This failure resulted in Resident 85 sustaining a fall with facial injuries requiring hospital transfer. 3.Resident 24, assistance device (call light) was not within reach.This failure had the potential to result in the resident being unable to request for assistance, placing her at risk for injury.Findings: 1.On February 9, 2026, at 9:44 a.m., a concurrent observation and interview with Resident 34 was conducted in her room. Resident 34 stated she smokes cigarettes with supervision and was observed to have cigarettes and a lighter at bedside. A review of Resident 34's admission Record dated February 12, 2026, indicated an admission date of December 23, 2025, with diagnoses which included metabolic encephalopathy (brain dysfunction). A review of Resident 34's History and Physical dated December 24, 2025, indicated resident had the capacity to understand and make decisions. A review of Resident 34's Smoking assessment dated [DATE], indicated, .Safety factors.burns skin, clothing, furniture or other.drops ashes on self.Recommendation.smoke with supervision. On February 11, 2026, at 11:13 a.m., a concurrent interview and record review with Licensed Vocational Nurse (LVN) 15 was conducted. LVN 15 stated residents are not allowed to keep cigarettes and lighters at bedside. LVN 15 stated all staff are responsible for ensuring smoking paraphernalia is not kept at bedside without staff knowledge. LVN 15 stated is a resident does not want to surrender smoking paraphernalia to staff, an Interdisciplinary Team (IDT) meeting should be completed and should be care planned. LVN 15 stated there was no documented evidence that an IDT meeting was conducted, or care plan was initiated related to Resident 34 keeping her smoking paraphernalia at bedside. LVN 15 stated she was not aware Resident 34 had cigarettes and a lighter at bedside and Resident 34 should not have had these items at bedside, since an IDT was not done and it was not included in the care plan. LVN 15 stated it was important to follow the facility's protocol for managing smoking paraphernalia to prevent resident harm and risks for safety and fire. On February 12, 2026, at 10:47 a.m., an interview with the Assistant Director of Nursing (ADON) was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted. The ADON stated if a resident is alert and oriented times four and requested to have their smoking paraphernalia at bedside, staff should have conducted an IDT meeting, informed the physician, initiated a care plan, and provided education on safety. The ADON stated there was no documented evidence that an IDT meeting was conducted, the physician was notified, and a care plan initiated. The ADON stated Resident 34 should not have had cigarettes and a lighter at bedside. The ADON stated this was important to ensure safety for all residents. A review of the facility's policy and procedures titled, Resident Smoking, dated October 20, 2025, indicated, .provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking.Smoking materials.maintained by designated staff. 2. A review of Resident 85's admission Record dated February 17, 2026, indicated the resident was admitted to the facility on [DATE], with diagnoses including abnormalities of gait and mobility. A review of Resident 85's History and Physical dated October 24, 2025, indicated the resident did not have the capacity to understand and make decisions. A review of Resident 85's Fall Risk Assessment, dated October 23, 2025, indicated Resident 85 was at risk for falls. A review of Resident 85's Minimum Data Set (an assessment tool) dated January 10, 2026, indicated Resident 85 required supervision or touching assistance for chair/bed to chair transfer. A review of Resident 85's SBAR (Situation, Background, Appearance, Review and Notify) Communication Form, dated January 26, 2026, indicated .At approximately 11:15, resident had an unwitnessed fall and was found laying (sic)on the floor in a prone position .Verbal and able to follow commands. No changes to LOC (level of consciousness) .send to ER . A review of Resident 85's Care plan indicated there was no revisions of the care plan addressing the resident's behavior of attempting to transfer independently without supervision after becoming aware of the resident's behavior prior to the fall. On February 11, 2026, at 12:05 p.m., an interview was conducted with CNA 3, CNA 3 stated Resident 85 fell face forward while attempting to transfer from her wheelchair to the bed and sustained facial injuries. CNA 3 stated Resident 85 could perform transfers with supervision. CNA 3 stated Resident 85 was a fall risk, and it was not safe to be left unattended in the wheelchair. CNA 3 stated she previously observed Resident 85 transfer herself from the wheelchair to the toilet without supervision and did not report to the licensed nurse and she should have. On February 11, 2026, at 12:15 p.m., an interview was conducted with CNA 4. CNA 4 stated on January 26, 2026, she heard a noise coming from Resident 85's room and found the resident on the floor. CNA 4 stated the resident had black eyes, swelling to the nose, knot on the head, and nose was bleeding. CNA 4 stated the resident was sent to the hospital. CNA 4 stated Resident 85 had a history of attempting to get up on without staff assistance and that staff were aware of this behavior. On February 11, 2026, at 2:48 p.m., an interview was conducted with CNA 5. CNA 5 stated she was aware Resident 85 would attempt to stand from the wheelchair independently. CNA 5 stated, on January 26, 2026, she was covering for Resident 85's assigned CNA. CNA 5 stated she last saw the resident in the dining room and did not know when the resident returned to her room as she was assisting another (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. On February 12, 2026, at 10:47 a.m., an interview with the Assistant Director of Nursing (ADON) was conducted. ADON stated CNAs were expected to report unsupervised transfer attempts to the licensed nurse so that a fall risk assessment could be completed and the behavior care planned. The ADON stated Resident 85's behavior of attempting to transfer independently should have been reported and addressed through updated care planning. The ADON stated Resident 85 should not have been left unattended in her wheelchair and her attempts to get up without supervision should have been reported to the nurse. The ADON stated this was important to prevent accidents, harm, and falls. A review of the facility's policy and procedure titled, Fall Prevention Program, dated December 28, 2023, indicated, Each resident .will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls . provide additional interventions as directed by the resident's assessment . A review of the facility's policy and procedure titled, Fall Risk assessment dated [DATE], indicated, . provides supervision . to each resident to prevent avoidable accidents . risk assessment will be completed by the nurse . when a significant change is identified . risk assessment will contain .individual risks, including the need for supervision .fall care plan will include interventions, including adequate supervision . to reduce the risk of an accident . 3. On February 10, 2026, at 8:35 a.m., Resident 24 was heard yelling from inside her room. Upon entering, Resident 24 was observed in bed with her call light hanging to the side of the bed and not within reach. Resident 24 stated she wanted her bedside table moved. Resident 24 stated she was unable to locate her call light. A review of Resident 24's admission Record, indicated Resident 24 was admitted to the facility on [DATE], with diagnoses which included frequent falls. A review of Resident 24's History and Physical, dated January 20, 2026, indicated Resident 24 does not have the capacity to understand and make decisions. A review of Resident 24's Care Plan dated January 28, 2026, indicated .The resident is at risk for falls r/t (related to) Gait/balance problems, Unaware of safety needs, History of Fall .Place resident's call light is within reach.The resident needs prompt response to all requests for assistance . On February 10, 2026, at 8:37 a.m., during a concurrent observation and interview with Licensed Vocational (LVN) 1, LVN 1 stated Resident 24's call light was not within reach, and it should have been. LVN 1 stated if the call light was not within her reach, the resident would be unable to request assistance, including during an emergency. A review of facility Policy and Procedure titled Call Lights: Accessibility and timely Response, dated December 19, 2022, indicated .Staff will ensure the call light is within reach of resident and secured as needed.