| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056162 | A. Building<br>B. Wing | 02/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Extended Care Hospital of Riverside | 8171 Magnolia Avenue<br>Riverside, CA 92504 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**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:<br><br>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.<br><br>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).<br><br>A review of Resident 34's History and Physical dated December 24, 2025, indicated resident had the capacity to understand and make decisions.<br><br>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.<br><br>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.<br><br>On February 12, 2026, at 10:47 a.m., an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated if a resident is alert and oriented times four and requested to have their<br>(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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>A review of Resident 85's Fall Risk Assessment, dated October 23, 2025, indicated Resident 85 was at risk for falls.<br><br>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.<br><br>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 .<br><br>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.<br><br>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.<br><br>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.<br><br>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 resident.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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 .<br><br>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 .<br><br>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.<br><br>A review of Resident 24's admission Record, indicated Resident 24 was admitted to the facility on [DATE], with diagnoses which included frequent falls.<br><br>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.<br><br>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 .<br><br>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.<br><br>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. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. Physician orders with parameters were followed when medications were administered without documenting the systolic blood pressure for one of three residents reviewed after medication pass observation. This failure had the potential for residents to inadvertently receive medications when they need to be held according to the physician's orders. 2. medications contained in the medication carts were not discontinued or discharged and not stored in the cart along with active residents' medications. This failure had the potential for discontinued medications to be used as not intended; 3. there was accurate accounting of Scheduled II controlled substances (federal designation of a class/classes of medications with the highest addictive potential) to minimize misuse and abuse when one dose of Resident 58's generic Norco (potent opioid used to treat severe pain) 5 mg was removed from the blister card without documentation of administration in the resident's medical record. 4. Lidoderm (topical patch to treat local pain) 5% patches were applied to Resident 63 for 12 hours as instructed in the physician order. This failure had the potential for the resident to receive inadequate pain control.1. On February 9, 2026, at 10 a.m., during a medication pass observation, LN 15 prepared and administered to Resident 79 eight oral medications including carvedilol (medication to treat high blood pressure) 3.125 mg. It was observed six of the eight medications were crushed and mixed with apple sauce. On February 9, 2026, a review of Resident 79's electronic medical record (EMR) indicated: Resident 79 was [AGE] years old, admitted to the facility on [DATE], with diagnoses which included atherosclerotic (hardening of blood vessels) heart disease of native coronary (heart) artery and essential hypertension (high blood pressure); Resident 79 had a physician order on [DATE], to receive carvedilol (medication to treat high blood pressure and heart disease) 3.125 mg (milligram, unit of measurement) one tablet by mouth two times a day for hypertension and hold if SBP (systolic blood pressure, the top number of the blood pressure reading, maximum pressure in your arteries when your hear contracts and pumps blood) is less than 110 mm Hg (millimeter mercury, blood pressure measurement) or if the heart rate is less than 60 beats per minute; Resident 79's [DATE] the medication administration record (MAR) for carvedilol did not document SBP; and Resident 79's February 2026 the MAR did not document SBP. On February 9, 2026, at 3 p.m., during an interview, LN 15 stated there was no place in the MAR to document SBP. LN 15 stated one would not be able to document SBP since there was no field to document in MAR. The facility's policy and procedure titled, Medication Errors, undated, was reviewed, and it indicated: .To prevent medication errors and ensure safe medication administration, nurses should verify the following information .right documentation . The facility's policy and procedure titled, Medication Administration, effective, [DATE], was reviewed, and it indicated: .Medications are administered by licensed nurses .as ordered by the physician and in accordance with professional standards of practice .Obtain and record vial signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters . 2. On February 10, 2026, at 1 p.m., during an inspection of the medication cart (Cart 1) located at Nursing Station 1, there was a bottle of megestrol (medication to increase appetite) 40 mg/ml (milligram per milliliter, unit of measurement) and one blister card containing hydroxyzine (medication to treat skin rash or itching) for Resident 17. During a concurrent interview, LN 16 stated both medications were discontinued and not active. LN 16 stated they should not have been in Cart 1 and discarded properly. Resident 17's medical record was reviewed on February 10, 2026, and it indicated hydroxyzine 25 mg was discontinued on [DATE] and megestrol 40 mg/ml was discontinued on [DATE]. The facility's policy and procedure titled, Discontinued Medications, revised, [DATE], was reviewed, and it indicated: .When medications are expired, discontinued by a prescriber .the medications are marked as discontinued or stored in a<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | separate location and later destroyed . 3. On February 10, 2026, at 1:20 p.m., during an inspection of the medication cart (Cart 1) located at Nursing Station 1, there were two blister cards containing generic Norco 5 mg tablets and the corresponding Controlled Drug Record (CDR) for Resident 58's generic Norco 5 mg blister cards. Review of the generic Norco 5 mg CDR indicated one dose was removed and signed out by a licensed nurse on February 4, 2026, at 9 p.m. On February 10, 2026, Resident 58's medical record was reviewed, and it indicated: Resident 58 had a physician order on [DATE] for generic Norco 5 mg with the direction to give one tablet every 6 hours as needed for severe pain; There was a physician order on February 1, 2026 to discontinue the generic Norco 5 mg and there was no new or continuing order for the generic Norco 5 mg; and The Resident 58's medication administration record for generic Norco 5 mg indicated the last day the medication order was active was February 1, 2026, and no documentation of administration of generic Norco 5 mg was present after February 1, 2026. On February 10, 2026, at 2:50 p.m., in an interview, LN 16 confirmed one dose of the generic Norco 5 mg was removed from the blister card, signed out on the CDR by a licensed nurse on February 4, 2026, after the generic Norco 5 mg was discontinued, and no documentation of administration on Resident 58's medical record. LN 16 agreed due to the absence of documentation, there was no way to tell if the medication was administered to Resident 58 or another resident. The facility's policy and procedure, titled, Controlled Substance Administration & Accountability, revised, [DATE], was reviewed, and it indicated: .All controlled substances (Schedule II, III, IV, V) are accounted for .All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided .In all cases, the dose noted on the usage form .must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form and placed in the patient's medical record . 4. On February 11, 2026, Resident 63's medical record was reviewed, and it indicated: Resident 63 was [AGE] years old, admitted to the facility on [DATE], with diagnoses which included hemiplegia (paralysis of one side) following cerebral infarction (stroke) and symptoms and signs involving musculoskeletal (related to muscles and bones) system; The resident had a physician order on [DATE] for Lidoderm Patch 5% with the direction to apply to lower lumbar (lower back) topically on in AM (morning), off at HS (bedtime) for back pain and remove per schedule; The Resident 63's medication administration record (MAR) for [DATE], indicated Lidoderm patches were applied at 9 a.m. and removed at 6 p.m.; The Resident 63's MAR for February 2026, indicated Lidoderm patches were applied at 9 a.m. and removed at 6 p.m. On February 12, 2026, at 4:05 p.m., in an interview, LN 17 stated dosing time of HS (bedtime) would be 8 or 9 p.m. On February 12, 2026, at 4:10 p.m., in an interview, the ADON stated dosing time of HS would be 9 p.m. On February 11, 2026, at 12:15 p.m., in an interview, the ADON stated the Lidoderm patch order was revised for the patch to be applied for 12 hours for the resident.The manufacturer's prescribing information for Lidoderm Patch 5% indicated, Apply Lidoderm to intact skin to cover the most painful area. Apply the prescribed number of patches (maximum of 3), only once for up to 12 hours within a 24 hour period. The facility's policy and procedure titled, Medication Administration - General Guidelines, effective, [DATE], was reviewed, and it indicated: .Medications are administered as prescribed in accordance with good nursing principles and practices .Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule . |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide required information and follow up with the resident's representative (RP) regarding Advance Directives (AD - written statement of a person's wishes regarding medical treatment) for one of one resident reviewed for AD (Resident 6), who lacked decision-making capacity.This failure had the potential to prevent the resident's representative from participating in medical decision-making and ensuring the resident's treatment preferences were honored. Findings:A review of Resident 6's admission record dated February 12, 2026, indicated Resident 6 was admitted on [DATE], with a diagnoses which included dementia (progressive cognitive impairment).A review of Resident 6's History and Physical dated August 5, 2025, indicated Resident 6 does not have the capacity to understand and make decisions. A review of Resident 6's POLST dated December 7, 2023, indicated there was no documented AD for Resident 6.A review Resident 6's Quarterly Social Service assessment dated [DATE], indicated, .advance directive was not offered at this time the resident is confused.Further review of Resident 6's record indicated there was no documented evidence the facility followed up with the resident's representative to provide information or education regarding AD or conservatorship. On February 11, 2026, at 3:32 p.m., concurrent interview and record review with the Social Service Director (SSD) was conducted. The SSD stated residents were offered to formulate an AD and provided education upon admission and during quarterly assessments. The SSD stated if a resident lacks decision-making capacity, the resident's RP is contacted and informed of their right, including the right to file for conservatorship. The SSD stated Resident 6 did not have an AD since 2023, was not offered to formulate an AD due to confusion, and follow-up with the RP was not conducted as required by facility practice. The SSD stated she should have followed up with the RP to allow participation in decision making.On February 12, 2026, at 10:47 a.m., an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated if the resident is confused and unable to consent to formulate an AD, the SSD should have informed the RP. The ADON stated there was no documentation the resident's representative was contacted regarding advance directives and stated the SSD should have. The ADON stated it was important to follow up with the RP to allow the RP to be involved in decision making and honor the resident's wishes.A review pf the facility's policy and procedure titled, Residents' Rights Regarding Treatment and Advance Directives, dated December 19, 2022, indicated, .In the event the resident is unable to formulate an AD due to cognitive impairment.the facility will provide information and education to the resident representative.The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer and failed to provide a written bed-hold notice to one of three residents reviewed for discharges (Resident 111) and or the resident representative at the time of transfer to the hospital.These failures had the potential to deny the resident the right to be informed of transfer and bed-hold rights, including the right to reserve and return to a bed. Findings:A review of Resident 111's admission Record dated February 13, 2026, indicated the resident was admitted on [DATE], with diagnoses including cirrhosis of the liver (irreversible liver damage).A review of Resident 111's History and Physical dated December 8, 2025, indicated the resident had fluctuating capacity to understand and make decisions.A review of Resident 111's Physician Progress Note dated December 18, 2025, indicated, .patient's family recently expressed concerns that she needs a paracentesis (a medical procedure in which a needle is inserted into the abdominal cavity to remove excess fluid) and requested hospital transfer.A review of Resident 111's SNF/NF to Hospital Transfer Form dated December 18, 2025, indicated resident was transferred to hospital for paracentesis.There was no documented evidence that a written notice of transfer was provided to the resident or resident representative (RP).On February 13, 2026, at 3:13 p.m., a concurrent interview and record review were conducted with the Assistant Director of Nursing (ADON). The ADON stated it was the licensed nurse's responsibility to provide the written notice of transfer to the resident and RP prior to the resident leaving the facility. The ADON stated there was no documented evidence that the notice of transfer was provided and stated the notice should have been provided to ensure a safe discharge. A review of the facility's policy and procedure titled, Transfer and Discharge (including AMA), dated December 19, 2022, indicated, The facility's transfer/discharge notice will be provided to the resident and the resident's representative.provided.prior to facility-initiated transfer or discharge.must be provided to the resident, resident's representative if appropriate. 2.A review of Resident 111's admission Record dated February 13, 2026, indicated an admission date of December 7, 2025, with diagnoses including cirrhosis of the liver (irreversible live damage).A review of Resident 111's History and Physical dated December 8, 2025, indicated the resident had fluctuating capacity to understand and make decisions.A review of Resident 111's SNF/NF to Hospital Transfer Form dated December 18, 2025, indicated resident was transferred to hospital for paracentesis and resident representative was notified of transfer.There was no documented evidence that a written bed-hold notice was provided to the resident or representative party (RP) at the time of transfer.On February 13, 2026, at 4:26 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated the licensed nurse was responsible for completing the bed-hold form and informing the resident or RP prior to transfer to the hospital. The DON stated there was no documented evidence that a bed-hold notice was provided to Resident 111 or the RP. The DON stated a bed-hold notice should have been provided to Resident 111 or the RP to inform the resident of the right to reserve and return to a bed and promote continuity of care.A review of the facility policy and procedures titled, Bed Hold Notice Upon Transfer, dated December 19, 2022, indicated, .At the time of transfer for hospitalization.the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy.the facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate Pre-admission Screening and Resident Review (PASARR) and referral for one of three residents reviewed for PASARR (Resident 5) when the resident was admitted with documented diagnoses of major depressive disorder and psychosis and was not referred to the State-Designated Authority (SDA) for a PASARR Level II evaluation. This had the potential to prevent a determination of the resident's need for specialized mental health services and prevented incorporation of PASARR recommendations into the resident's comprehensive care plan. Findings:On February 11, 2026, Resident 5's record was reviewed. Resident 5 was admitted on [DATE], with diagnoses that included unspecified psychosis (loss of contact with reality) and major depressive disorder (a mood disorder). The document titled, History and Physical, dated December 4, 2025, indicated .Medical History .psychosis .has fluctuating capacity to understand and make decisions. The PASARR Level I, dated November 13, 2025, indicated, . Diagnosed Serious Mental Illness. Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance .No. The document titled, Adult Psychosocial Assessment. Dated November 12, 2025, indicated, .resident endorses depression.diagnosis.major depressive disorder, recurrent, moderate.difficulties including feeling sad, depressed, feeling overwhelmed, irritability and difficulty concentrating, endorses sleep disturbances, fatigue, stay in bed all day, low motivation, feeling on edge and depressed mood.plan to continue Vilazodone (antidepressive medicine) oral tablet 20 mg (milligrams - a unit of measurement) daily. There was no documented evidence that the facility corrected PASARR screening or referred Resident 5 to the SDA for PASARR level II evaluation upon identifying the mental health diagnoses. On February 11, 2026, at 11:44 a.m. an interview and record review was conducted with the Minimum Data Set Coordinator (MDS). The MDS stated Resident 5 had a negative PASARR level one screening that was completed by the hospital and received by the facility prior to admission. The MDS Coordinator stated the MDS, Section I indicated Resident 5 had a diagnosis of Psychosis and Major depressive disorder entered on November 11, 2026. The MDS Coordinator further stated a new PASARR screening and referral should have been conducted and that it was not. A review of the facility policy and procedure titled, Resident Assessment - Coordination with PASARR Program, dated December 2023, indicated, .The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or a related condition to the appropriate stated-designated authority for Level II PASARR evaluation and determination.any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder. |

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|---|---|---|---|
| | 056162 | A. Building<br>B. Wing | 02/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Extended Care Hospital of Riverside | 8171 Magnolia Avenue<br>Riverside, CA 92504 |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor and assess an intravenous (IV - intravenous catheter inserted into the vein to deliver fluids and medication) site for one of one resident reviewed for parenteral (administered by injection) fluids (Resident 124) according to facility policy.This failure had the potential to result in undetected IV-related complications including infection, infiltration, or inflammation of a vein.Findings:A review of Resident 124's admission Record dated February 12, 2026, indicated the resident was admitted on [DATE], with a diagnosis which included urinary tract infection (UTI - an infection in the urinary tract).A review of Resident 124's History and Physical dated February 3, 2026, indicated resident had the capacity to understand and make decisions.A review of Resident 124's Physician Orders dated February 13, 2026, indicated an order for Ertapenem (a broad-spectrum antibiotic used to treat serious bacterial infections) 500 milligrams (mg - a unit of measurement) intravenously every 24 hours for UTI for 7 days and no order for monitoring the IV site.A review of Resident 124's February 2026 Medication Administration Record (MAR) indicated Ertapenem 500 mg intravenously was administered daily from February 4, 2026, to February 9, 2026.There was no documented evidence that the IV site was monitored or assessed during the period the IV antibiotic was administered.On February 12, 2026, at 8:29 a.m., a concurrent interview and record review were conducted with the Registered Nurse Supervisor (RNS). The RNS stated IV sites should be monitored and assessed each shift for complications and documented in the MAR by the RNS. The RNS stated there was no documented evidence that monitoring and assessments were performed for Resident 124's IV site during the course of IV therapy. The RNS stated it was important to monitor and assess the IV site to ensure there were no complications or potential infection to the resident.On February 12, 2026, at 10:47 a.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated it was the responsibility of the RNS to assess IV sites every shift and document the assessment. The ADON stated there was no documented evidence that IV site monitoring or assessments were completed for Resident 124. The ADON stated monitoring the IV site was important to prevent complications and infection. A review of the facility's policy and procedure titled, Intravenous Therapy, dated December 19, 2022, indicated, .IV sites are checked.per facility protocol and PRN for signs and symptoms of infection.nurse will assess for associated risks.IV documentation is recorded in the.Medication Administration Record. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure medications that required refrigeration were not stored outside of the refrigerator at room temperature. This failure had the potential for residents to receive ineffective medications.On February 10, 2026, at 12:40 p.m., during an inspection of the medication cart (Cart 1) located at Nursing Station 1, there was an amber bottle containing approximately 80 ml (milliliter, unit of measurement) of gabapentin (medication to treat seizure) 250 mg (milligram, unit of measurement) per 5 ml solution for Resident 55. The gabapentin bottle had an auxiliary label that indicated, Refrigerate. During a concurrent interview, LN 16 confirmed the bottle was stored in Cart 1 at room temperature and stated it should have been in the medication refrigerator. The facility's policy and procedure titled, Medication Storage, effective, December 19, 2022, was reviewed, and it indicated: It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper .temperature .All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room . According to the manufacturer's prescribing information for gabapentin oral solution indicated, Store refrigerated . |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a diet in accordance with physician's orders for one of 19 residents reviewed during dining observation (Resident 14), when the resident, who had a documented allergy to nuts was served a brownie containing nuts.This failure placed the resident at risk for an allergic reaction.Findings:On February 9, 2026, at 12:32 p.m., Resident 14 was observed eating in the dining room. Resident 14 was served a dessert brownie which contained nuts.Resident 14 stated he did not want to eat the brownie because it contained nuts and further stated he had an allergy to nuts. Resident 14 stated he would not eat anything containing nuts because he would react in a bad way and could developed seizures (convulsions).A review of Resident 14's tray card indicated, .Allergies: Peanuts and Tree Nuts .A review of Resident 14's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included acute respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Resident 14's History and Physical indicated Resident 14 had the capacity to understand and make decisions.Resident 14's Nutritional assessment dated [DATE], indicated .Food Allergies: nuts, nitrates .Resident 14's Physician's order dated January 7, 2026, indicated .Allergy Report: Food Allergy- Peanuts.A review of the recipe titled Turtle Brownie (Mix) Indicated .Ingredients .Nuts, Pecan, pieces medium.On February 12, 2026, at 10:22 a.m., the Licensed Vocational Nurse (LVN) 2 was interviewed. LVN 2 stated he checked trays before they were delivered to residents. The LVN 2 stated he did not know the brownie contained nuts and stated he should have verified the ingredients with dietary staff prior to delivering the tray. LVN 2 further stated the resident could have developed shortness of breath as an allergic reaction. On February 12, 2026, at 10:28 a.m., the Dietary Service Supervisor (DSS) was interviewed. The DSS stated Resident 14 should not have served the brownie because it contained nuts. The DSS stated staff should verify ingredients when a resident has a documented allergy and stated that serving nuts to a resident with a nut allergy could result in hospitalization due to an allergic reaction. A review of the facility Policy and Procedure titled, Resident Food Preferences, dated April 30, 2021, indicated .Food Preferences, allergies should be recorded on the resident's tray card .these.allergies, intolerances should be honored. |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician-ordered therapeutic diet (a diet ordered by a physician as part of resident's medical treatment to manage a disease or condition) was followed for one of 19 residents reviewed for nutrition (Resident 90), when the resident was not provided the ordered minced and moist diet texture at lunch on February 12, 2026. This failure had the potential to result in decreased nutritional intake and increased risk for choking due to the resident's dysphagia (difficulty swallowing).Findings:On February 12, 2026, at 12:40 p.m., Resident 90 was observed in the dining room being assisted by Certified Nurse Assistant (CNA) 1 with CNA 2. Resident 90 stated he was not able to chew the chicken breast because it was spongy. Resident 90 stated he could only suck on the chicken and could have finished the meal if it had been a softer consistency. CNA 1 stated the meal served as soft and bite-sized and stated the resident's diet should have been minced and moist consistency. CNA 1 stated Resident 90 consumed approximately 25% of the meal. During a concurrent observation and interview with CNA 2, CNA 2 attempted to cut the chicken with spoon and stated the chicken was not soft enough and could be difficult to chew. A review of Resident 90 ?s admission Record indicated, the resident was admitted to the facility on [DATE], with diagnoses which included dysphagia. A review of the History and Physical dated January 14, 2026, indicated Resident 90 has fluctuating capacity to understand and make decisions. A review of Resident 90's Minimum Data Sheet (an assessment tool) Section L Oral/ Dental Status indicated .(edentulous) No Natural teeth or tooth fragment(s). A review of Resident 90's Physician's order dated February 3, 2026, indicated .CCHO (Consistent Carbohydrate Control diet- aims to stabilize blood sugar levels) Minced & Moist (MM5- food texture to improve safety for individual with swallowing difficulty) Texture, Thin (TN0) Consistency. The meal served on February 12, 2026, was not minced and moist in texture as ordered. On February 12, 2026, at 2 p.m., during an interview with the Dietary Service Supervisor (DSS), the DSS stated the physician's diet order for Resident 90 should have been followed. The DSS further stated when the order was not followed there was a potential for decrease intake and an increased risk for choking. A review of the facility Policy and Procedure titled Therapeutic Diet Orders, dated May 17, 2023, indicated .The Therapeutic Diet, including mechanically altered diets.will be based on individual needs as determined by resident assessment.in certain situations, such as Swallowing difficulty. The Dietary and Nursing staff are responsible for providing therapeutic diets. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure food safety requirements for food storage and preparation were followed when one expired 12-ounce Tabasco sauce was found in the dry storage room readily available for use. This failure had the potential to place the residents at risk for food-borne illness in a medically vulnerable population of 82 residents who consumed food prepared by the facility. Findings:On February 9, 2026, at 8:35 a.m., during the initial kitchen tour, one 12-ounce bottle of Tabasco sauce was observed on a dry storage shelf readily available for use. The bottle was labeled with an open date of October 26, 2025, and a manufacturer's best-by date of December 2025, which had expired. During a concurrent interview with the Dietary Service Supervisor (DSS), the DSS stated the sauce should have been discarded. The DSS stated there was potential for food borne illness if the expired product were used. On February 12, 2026, at 2:27 p.m., the Registered Dietician (RD) was interviewed. The RD stated expired food items should be discarded, and that consumption of expired products could cause gastrointestinal illness. A review of the facility Policy and Procedure titled Date Marking for Food Safety, dated December 19, 2022, indicated .The facility adheres to a date marking system to ensure the safety of ready-to-eat .food.The discard date may not exceed the manufacturer's use-by-date. |