

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2025
NAME OF PROVIDER OR SUPPLIER Arlington Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3688 Nye Avenue Riverside, CA 92505	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure grooming was provided when one resident (Resident 1) who was observed with long fingernails did not receive on-going grooming services. This failure had the potential for Resident 1 to be at risk for avoidable skin injuries. Findings: On August 25, 2025, an announced visit was conducted at the facility to investigate a complaint. On August 25, 2025, at 2:33 p.m., Resident 1 was interviewed. Resident 1 was alert, oriented, and well-dressed. Resident 1 was observed with long fingernails on her right hand and stated she would like to have her fingernails cut. On August 25, 2025, at 2:38 p.m., a concurrent observation, interview and record review was conducted with the treatment nurse. The Treatment Nurse (TN) was observed measuring Resident 1's fingernails on her right hand. The following measurements were observed, right index fingernail 1.6 cm (cm- centimeters a unit of measurement), right middle fingernail 1.8 cm, right ring fingernail 1.9 cm, and right pinky fingernail 1.6 cm. The TN stated it is the responsibility of the TN and the certified nurse assistant (CNA) to care for residents' fingernails. The TN further stated Resident 1's long fingernails should have been addressed by the TN and/or the CNA. On August 25, 2025, Resident 1's medical record was reviewed. The admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (loss of intellectual functioning), hypertension (high blood pressure), acute kidney failure (decline if kidney function). The history and physical completed on January 31, 2025, indicated Resident 1 had no decision-making capacity. On August 27, 2025, at 2:11 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility policy on nail care is for the CNA, TN, and/or licensed nurses (LN) to conduct nailcare on a resident's fingernails during resident's care. The DON stated the CNA, TN, and/or LN should have addressed Resident 1's nails during resident's routine care. A review of the facility policy and procedure titled Fingernails/Toenails, Care of, dated 2001, indicated .nail care includes daily cleaning and regular trimming. proper nail care can aid in the prevention of skin problems around the nail bed. trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Stop and report to the nurse supervisor. evidence of ingrown nails. pain. nails are too hard or too thick to cut with ease.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056485
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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure foot care was provided when one resident (Resident 1) who was observed with long toenails and did not receive on-going podiatry (foot care provided by a specialty doctor) care. This failure had the potential for Resident 1 to be at risk for avoidable skin injuries. Findings: On August 25, 2025, an announced visit was conducted at the facility to investigate a complaint. On August 25, 2025, at 2:33 p.m., Resident 1 was interviewed. Resident 1 was alert, oriented, and well-dressed. Resident 1 stated she had painful toenails. On August 25, 2025, at 2:38 p.m., a concurrent observation, interview and record review was conducted with the Treatment Nurse (TN). Resident 1 was observed with long curved toenails on both feet. The TN was observed measuring Resident 1's toenails on her left foot. The following measurements were observed, left great toenail 2.0 cm (centimeters-a unit of measurement), left second toenail 0.7 cm, left third toenail 1.0 cm. Left fourth toenail 1.0 cm, and left pinky toenail 0.5 cm. The TN was further observed measuring Resident 1's toenails on her right foot. The following measurements were observed, right great toenail 2.5 cm, right second toenail 1.1 cm, right third toenail 1.0 cm, right fourth toenail 0.9 cm, and right pinky toenail 1.0 cm. The TN stated it is the responsibility of the TN and the certified nurse assistant (CNA) to care for residents' toenails. The TN further stated the nursing staff should have informed podiatry of Resident 1's long toenails. On August 25, 2025, Resident 1's medical record was reviewed. The admission record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (loss of intellectual functioning), hypertension (high blood pressure), acute kidney failure (decline if kidney function). The history and physical completed on January 31, 2025, indicated Resident 1 had no decision-making capacity. The podiatry note dated April 10, 2025, indicated . Resident 1. onychomycosis (fungal infection toenails). dystrophic nails (abnormal nail shape, color, texture, or growth). paronychia (inflammation of skin surrounding toenail). with painful nail boarders. There was no documented evidence Resident 2 was seen by a podiatrist after April 10, 2025. On August 27, 2025, at 2:11 p. m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility policy on nail care is for the CNA, TN, and/or licensed nurses (LN) to conduct nailcare on a resident during resident's routine care. The DON stated the CNA, TN, and/or LN should have scheduled podiatry services for Resident 1's toenails. A review of the facility policy and procedure titled Fingernails/Toenails, Care of, dated 2001, indicated . nail care includes daily cleaning and regular trimming. proper nail care can aid in the prevention of skin problems around the nail bed. trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Stop and report to the nurse supervisor. evidence of ingrown nails. pain. nails are too hard or too thick to cut with ease.</p>		

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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)		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure supervision and monitoring was provided for one resident (Resident 3) when Resident 3 fell on four separate occasions within seven days. This failure had the potential for Resident 3 to experience avoidable accidental injuries. Findings: On August 25, 2025, an announced visit was conducted at the facility to investigate a complaint. On August 25, 2025, at 2:26 p.m., Resident 3 was interviewed. Resident 3 was alert and oriented. Resident 3 was observed in bed dressed and well groomed. Resident 3 stated he was unsure how many times he fell at the facility, but he remembers going to the hospital for a fall. On August 25, 2025, Resident 3's medical records were reviewed. The admission record indicated Resident 3 was admitted to the facility on [DATE], with the diagnoses which included hemiplegia (paralysis affecting one side of the body), hemiparesis (brain injury affecting one side of the brain), diabetes mellitus (high blood sugar), and Parkinsons (progressive brain disorder). The history and physical completed on August 4, 2025, indicated Resident 3 had limited capacity to make decisions. The Situation Background Assessment Recommendation (SBAR) Notes for Resident 3 indicated the following: On August 11, 2025, at 9:15 p.m., [unwitnessed fall on anticoagulants. LVN (Licensed Vocational Nurse) entered patients' room. patient lying on the floor next to bed. patient stated hit their head. no laceration or bump. c/o mild pain. Registered Nurse notified. neuro checks. transferred to hospital. On August 17, 2025, at 8:00 p.m., [unwitnessed fall. around 8:00 pm patient found on the floor in sitting position. patient stated did not hit his head slide off bed. no bruises or skin tears. pain 0/10. care plan completed. medical doctor and family made aware. no new orders. The care plan for Resident 3 indicated the following: On August 4, 2025, [Resident is at risk for falls. Intervention. maintain keep bed low position. side rails. keep bed in low position with brakes locked. Side rails up while in bed to aid in bed mobility and repositioning. maintain safe hazard free environment. On August 11, 2025, [unwitnessed fall. Discharge/Transfer Acute Hospital: Resident requires transfer to an acute hospital due to: Fall beside the bed, pt alert x 4, using blood thinner medication. Intervention. communicate condition/transfer to the responsible party/POA/legal guardian. On August 12, 2025, [Resident had unwitnessed fall. goal. Will be compliant with fall interventions to reduce risk for additional falls. Will minimize risk for additional falls to the extent possible. Intervention. transfer to emergency room for evaluation of fall. keep bed in low position with brakes locked. Monitor for complications related to the fall. On August 18, 2025, [Resident had an unwitnessed fall. goal same as August 12, 2025. Intervention. 1:1 Sitter provided. Continue use of low bed and bilateral floor mats. On August 27, 2025, at 1:47 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 3 had four falls. The DON stated Resident 3's first fall was on August 11, his second fall was on August 12, his third fall was on August 15, and the fourth fall was on August 17, 2025. The DON reviewed Resident 3's care plan and verified the following interventions were implemented after Resident 3's first and second fall dated August 11 and August 12, 2025, [transfer to acute care hospital. resident was educated to call for assistance. low bed. floor mats on both sides of bed. bed alarm. wheelchair alarm. every two-hour monitoring. continue antibiotic therapy for urinary tract infection. The DON reviewed Resident 3's care plan and verified the following interventions were implemented after Resident 3's third fall on August 15, 2025, [continue interventions from previous fall. change antibiotic therapy. The DON reviewed Resident 3's care plan and verified the following interventions were implemented after Resident 3's fourth fall on August 18, 2025, [continue low bed. bed alarm. floor mats. implement 1:1 sitter. The DON stated after Resident 3's second fall the family requested a sitter for the resident and for the resident to be moved closer to the nursing station. The DON stated there were no rooms closer to the nurses' station and they did not assign a sitter because the facility wanted to be less restrictive. The DON further stated that all residents are monitored every two hours, so this would not be considered an intervention to prevent Resident 3's falls. The DON stated Resident 3 should have been rounded (monitored) more frequently and should have had a sitter assigned prior to his fourth fall. The DON stated possible outcomes of Resident 3's continued falls could have been a fracture or serious injury due to Resident 3 being on blood thinner medication. A review of the facility policy and procedure titled Falls Clinical Protocol, dated 2001, indicated [as part of the initial assessment. the physician will help identify. history of falls and risk factors. staff will evaluate and document fall that occur while individual is in the facility. staff and physician will identify pertinent interventions to try to prevent subsequent falls.</p>		