STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056485	A. Building B. Wing	10/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Gardens Care Center	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)
F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1), who required constant supervision and a pureed diet due to dementia and dysphagia, was discharged to a safe and appropriate setting. The facility did not verify that the receiving environment could meet the resident's care needs and discharged the resident to an unlicensed room and board with no caregivers and no understanding of her medical requirements. The facility's failure to ensure a safe and appropriate discharge for Resident 1 created an immediate jeopardy to resident health and safety. Without immediate intervention, other residents could be discharged to unlicensed or unsafe settings without necessary supervision, posing an ongoing and likely risk of serious harm, injury, or death. Immediate action is required to verify the safety of all current discharges, implement safe-discharge policies, and train staff to prevent recurrence.On October 15, 2025, at 3:36 p.m., The Administrator (ADM) and Director of Nursing (DON) were verbally notified of the immediate jeopardy.On October 16, 2025, the ADM and the DON submitted a removal plan which was accepted on October 17, 2025. The removal plan included the following:a. On October 15, 2023, the Social Service Director (SSD) and the Case Manager (CM)/Discharge Planner (DCP) reviewed 14 residents scheduled for possible discharge from October 15, 2025, to October 30, 2025, to ensure that each resident was appropriately assessed for discharge placement and that the receiving facility will be able to meet the residents' needs;b. On October 15, 2025, the SSD and CM/DCP reviewed 24 residents who were discharged from October 1, 2025, to October 15, 2025, and ensured that each resident was safely discharged and the receiving facility was able to meet the residents' needs;c. On October 15, 2025, the DON conducted an in-service to the SSD and CM/CDP regarding appropriate discharge placement to ensure that residents are discharged to a safe location that can meet their needs;d. The receiving facility will send a representative to assess the resident's current condition and plan of care, which includes evaluation of diet, medications, functional abilities (such as transfers, bed mobility, and ambulation), and cognitive status;e. A checklist was created to identify the residents' needs and will be used to verify and acknowledge that they can manage the care of the resident;f. The SSD will continue to conduct admission assessments with initial plans for discharge in collaboration with IDT (Interdisciplinary Team - a group of healthcare professionals who collaborate to create and implement care plans for residents) and during stay their stay at the facility and coordinate with the resident or the responsible party for changes in the discharge plans and provide assistance as needed;g. The SSD and CM/DCP will continue to conduct post discharge follow-up to ensure safe discharge; andh. The SSD will report the number of discharges to different levels of care and report concerns as presented by residents or the responsible party on post discharge follow-up during quarterly QAA (Quality Assurance and Assessment - a part of Quality Assurance Performance Improvement utilized to improve quality and performance) meetings. The QAA will monitor compliance and trends and provide recommendations during the meeting.On October 20, 2025, at 4:04 p.m., the immediacy was removed in the presence of the DON upon verification of implementation of the removal plan.Non-compliance of F-627 remained at the scope and severity of D no actual harm with potential for more than minimal harm that is not immediate jeopardy.Findings:A review of Resident 1's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty or discomfort in swallowing) and dementia (memory loss and confusion).A review of resident 1's Physician History and Physical, dated June 16, 2025, indicated Resident 1 did not have decision-making capacity.A review of Resident 1's Progress Notes, indicated the following: a. June 20, 2025, .Prior to hospitalization resident lived at home with dtr (daughter) and goal is to return home once medically stable.; and b. July 11, 2025, Resident 1 attempted to leave the facility. Resident 1 was placed on close monitoring with 1:1 sitter (a person providing one-on-one supervision, to ensure resident's safety).A review of the SBAR (Situation, Background, Assessment, and Recommendation - a communication framework used to structure conversations about patient updates between team members) dated July 17, 2025, indicated a Certified Nursing Assistant (CNA) called the Licensed Vocational Nurse (LVN) to the room stating Resident 1 had difficulty swallowing. Resident 1 was observed by LVN coughing and the LVN had to perform the Heimlich maneuver (a first aid method for choking). A review of the Care Plan, dated July 18, 2025, indicated, Focus.Resident was having difficulty swallowing.Goal.The resident will have no choking episodes when eating.Interventions/Tasks.Diet to be followed as prescribed.Monitor for choking.A review of the Care Plan, dated August 8, 2025, indicated

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 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 interview and record review, the facility failed to maintain complete and accurate clinical records for one of four residents reviewed (Resident 1) when:1. Resident 1's Notice of Proposed discharged (Notice of Proposed Discharge - a written document from a healthcare facility that informs a resident and/or their representative of the facility's intent to end the resident's stay) issued on September 30, 2025 (the day of discharge), had signatures of the resident and her family. Resident 1 was cognitively impaired. In addition, Resident 1's family was not present when the NOPD was issued;This failure resulted in Resident 1 and her family not being able to exercise their right to appeal the proposed discharge to the state long-term care agency.2. The LVN (Licensed Vocational Nurse) did not accurately document the time of family notification when Resident 1 had a fall on August 10, 2025.This failure had the potential to prevent the family from making informed decisions, providing critical information to the care team, or being present during a moment of crisis.Findings:On October 13, 15, and 20, 2025, unannounced visits were conducted at the facility to investigate complaint allegations.1. A review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive and persistent loss of intellectual functioning, especially with impairment of memory, thinking and personality change).A review of resident 1's Physician History and Physical, dated June 16, 2025, indicated Resident 1 did not have decision-making capacity.A review of Resident 1's Brief Interview of Mental Status (BIMS - a cognitive assessment tool), dated August 15, 2025, indicated a score of 3 (severely impaired).A review of Resident 1's Notice of Proposed Discharge (NOPD - a written document from the healthcare facility, informing the patient that they be leaving the facility), dated September 30, 2025, indicated Resident 1 and the responsible party (RP) were informed on the same day Resident 1 was discharged . The NOPD was signed by Resident 1 and the RP.On October 16, 2025, at 2:44 p.m., a telephone interview was conducted with Resident 1's RP. She stated she requested a copy of Resident 1's medical records from the facility and noticed somebody signed her name on the NOPD communication form. The RP stated she did not go to the facility on September 30, 2025. The RP stated she would sign her name with her married last name and not with her [NAME] name. The RP also stated when she signs, she would spell out her middle name.On October 20, 2025, at 1:04 p.m., during a telephone interview with the Social Service Director (SSD) in the presence of the Director of Nursing (DON), the SSD stated Resident 1's RP did not come to the facility on September 30, 2025. The SSD stated the NOPD was given on September 30, 2025, on the same day Resident 1 was discharged . She stated the RP was given the NOPD on September 1, 2025, but there was no available place at that time for Resident 1 to transfer to. She stated a second NOPD was given to Resident 1 and the RP on September 30, 2025, since a place for transfer was established. The SSD stated Resident 1 signed the NOPD form but she was not sure if Resident 1 also signed for the RP. The SSD stated if the RP was informed via the telephone and it should be indicated in the NOPD form. The SSD stated the NOPD form was explained to Resident 1, who signed the form. The SSD was asked why Resident 1 was allowed to sign to the NOPD form when it was clearly stated Resident 1 had cognitive impairment. The SSD stated Resident 1 was alert.The SSD stated the RP did not get the chance to exercise their rights to appeal the discharge on [DATE].On October 20, 225, at 1:04 p.m., during an interview with the DON, she stated if a signature was obtained via the telephone, the document should include the date and name of the staff member obtaining the signature.A review of the facility policy titled, Transfer and/or Discharge Notice, revised March 2024 indicated, .Residents and/or representatives are notified in writing and in a language and format that understand at least thirty (30) days prior to transfer or discharge.Residents are permitted to stay in the facility and not be transferred or discharged unless.the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility.Residents have the right to appeal.a transfer or discharge through the state agency that handles appeals.2. A review of Resident 1's SBAR (Situation, Background, Assessment, and Recommendation - a communication framework used to structure conversations about patient updates between team members) Communication Form, dated August 10, 2025, indicated Resident 1 had a witnessed fall and Resident 1's daughter was notified on August 10. 2025, at 12 a.m.On October 20, 2025, at 1:33 p.m., during a concurrent interview and record review with the DON, she stated Resident 1 had a witnessed fall on August 10, 2025, with no injury. She stated a fall incident was considered a change in condition. She stated the resident's physician, and RP should be notified. The DON stated the documented