STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A263	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Behavioral Healthcare Center	4580 Palm Avenue Riverside, CA 92501

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505 Based on observation, interview, and record review, the facility failed to provide a safe resident environment for two of three sampled residents (Residents 1 and 2), when Resident 1's room remained across from Resident 2 who Resident 1 had alleged abused him. This failure had the potential to result in increased mental anguish and/or emotional distress for both Resident 1 and Resident 2, who was falsely accused. Findings: On June 6, 2024, at 10:00 a.m., an unannounced visit was made to the facility to investigate an abuse allegation involving two residents. A review of Resident 1's record indicated he was admitted to the facility on [DATE], with a diagnosis which included schizoaffective disorder (mental disorder where one experiences hallucinations, embrace false beliefs, and experience depression or mania). A review of Resident 1's History and Physical, dated February 6, 2024, indicated .Has the capacity to understand and make decisions . A review of Resident 1's progress notes titled, Behavior Note, dated June 4, 2024, indicated, .this client (Resident 1) was being verbally aggressive towards a male peer (Resident 2). The male peer was unaware of the comments being directed towards him .Client appear agitated andwas (sic) stating delusional statements . A review of Resident 1's progress notes titled Behavior Note, dated June 5, 2024, indicated, .Program Counselor (PC) approached the client and asked the client why they represented the behavior and the client proceeded to say, 'the guy across my room keeps bothering me telling me to buy him snacks and MP3 player and he won't stop bugging me' .PC reminded the client if there are ever any issues with anybody/anything to use the call light in their room and to reach out to staff immediately and ask for help instead of presenting aggressiveness as it does go against facility rules. PC reminded the client to keep going to group such as self-regulation and assertive training. Client receptive . (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's progress notes titled, Behavior Note, dated June 5, 2024, indicated, .it was reported to staff that male peer was allegedly talking about him, giggling behind him, and putting his genitalia down his throat a couple of months ago and male peer constantly thinking about this act as well .the client was directed to keep distance from male peer and reminded he was on BWQ15 .client was directed to reach out to staff with further concerns . During an observation and interview on June 6, 2024, at 11:18 a.m., outside Resident 1's room, Resident 1 stated loudly, while pointing at the room across from his, that black guy in that room, I'm tired of him, he won't stop bugging me (expletive word), making me buy him things, I don't have money. Resident 1's room was observed to be directly across from Resident 2's room, the resident who he had alleged abused him. During an interview on June 6, 2024, at 11:25 a.m., with Program Manager (PM) 1, PM 1 stated, she should have moved Resident 1 to another room. PM 1 stated she thought Resident 1's and Resident 2's room were far from each other. PM 1 stated, she did not realize the rooms were that close and directly across from each other. During an interview on June 6, 2024, at 2:35 p.m., with Program Counselor (PC), PC stated, on June 5, 2024 at 12:15 p.m., she was doing door monitoring when Resident 1 came to her and told her that Resident 2 stuck a finger up his butt and his male genitalia up his throat. PC stated, it was not the first time that it happened. PC stated, the day prior (June 4, 2024), Resident 1 started yelling very loudly and was frustrated. PC stated Resident 1 was talking about Resident 2, who was waiting by the pay phone, near the nurses station. PC stated Resident 1 was yelling the N word to Resident 2. PC stated she was aware that Resident 1's room was across Resident 2's room. During an interview on June 6, 2024, at 3:09 p.m. with PM 2, PM 2 stated, Resident 1 was fixated on Resident 2. PM 2 stated, Resident 1 and Resident 2 had an issue the day prior (June 4, 2024), before he made an allegation of abuse on June 5, 2024. PM 2 stated, Resident 1 was upset with Resident 2. PM 2 stated when Resident 1 made the allegation of sexual abuse, they talked about moving Resident 1. PM 2 stated, she thought the other manager was taking care of the room change. PM 2 stated the room change got lost in communication and Resident 1 should have been moved to a different room right away. During an interview on June 6, 2024, at 3:45 p.m. with the Assistant Director of Nursing (ADON), the ADON stated, if there was an allegation of abuse, one way of preventing further abuse was to change the resident's room.