

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Riverside Behavioral Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038</p> <p>Based on interview and record review, the facility failed to ensure one of the three sampled residents (Resident 10) was free from physical abuse when a Program Counselor (PC 1) had a physical altercation with Resident 10.</p> <p>This failure resulted in Resident 10's sustaining superficial scratches on both cheeks and redness on the forehead.</p> <p>Findings:</p> <p>On July 11, 2024, at 9:10 a.m., an unannounced visit was made to the facility to investigate an allegation of physical abuse.</p> <p>A review of Resident 10's records indicated she was admitted to the facility on [DATE], with a diagnosis of schizophrenia (a mental disorder that affects a person's ability to think, feel, and behave clearly), adjustment disorder with mixed disturbance of emotions and conduct (an emotional or behavioral reaction to a stressful event or change in a person's life)</p> <p>A review of Resident 10's History and Physical dated January 9, 2024, indicated, .has the capacity to understand and make decisions .</p> <p>A review of a document titled, Post-Event Review -V 2, dated July 1, 2024, at 12:45 p.m. indicated that Resident 10 was involved in an incident between her and a staff (PC 1) .client (Resident 10) lunged at staff and claims staff had struck her.</p> <p>A review of Resident 10's progress note titled Behavior Note, dated July 1, 2024, at 2:34 p.m., indicated, . that resident lunged at the counselor and began to scratch her face.</p> <p>A review of Resident 10's progress notes titled Health Note, dated July 1, 2024, at 7:23 p.m., indicated, .that resident had scratches to bilateral cheeks and raised area to forehead with slight swelling and redness present .</p> <p>(continued on next page)</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
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On July 11, 2024, at 10:35 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that around lunch time on July 1, 2024, she was preparing for coffee service when she noticed Resident 10 was upset while visiting Program Counselor (PC) 1 in PC 1's office inside the cafeteria. CNA 1 stated Resident 10 knocked on the door and seemed upset about something. CNA 1 stated she saw Resident 10 rushed inside the room, swinging her hands forward, and heard a loud sound. CNA 1 stated she ran inside the room and saw Resident 10 and PC 1 in a physical altercation, swinging their arms and hitting each other. CNA 1 stated she was able to hold Resident 10 back and another staff, a Registered Nurse (RN) 1, blocked PC 1 from attacking Resident 10.</p> <p>On July 11, 2024, at 2:30 p.m., an interview was conducted with the Program Manager (PM 1), and she stated she was notified about the incident between Resident 10 and PC 1. She stated in any emergency, staff are expected to de-escalate the situation and not harm any residents.</p> <p>On July 11, 2024, at 3:15 p.m., an interview was conducted with Director of Nursing (DON). The DON stated, all staff must take a required Professional Assault Crisis Training (Pro-Act - a training for professionals who work with individuals who present challenging behaviors) every 2 years. The DON stated this training prepares their staff to deal with assaultive residents. The DON further stated the staff should respond to assaultive residents based on the Pro-Act training. The DON stated that facility protocol during an emergency is that staff should stay calm and initiate Code [NAME] to get immediate assistance. The DON stated staff can guard themselves but should try to keep arms next to the body if possible. The DON stated, PC 1 did not follow the protocol.</p> <p>On July 15, 2024, at 9:33 a.m., an interview was conducted with Registered Nurse (RN 1), and she stated she was in the cafeteria standing near room [ROOM NUMBER] talking with CNA 1. RN 1 stated, out of nowhere and unaware of what's happening, she saw CNA 1 run quickly over to room [ROOM NUMBER]. RN 1 stated, when she got there, she saw CNA 1 pulling back Resident 10 from an altercation with PC 1. RN 1 stated she had to stand in between Resident 1 and PC 1, because PC 1 kept trying to attack. RN 1 further stated Resident 10 complained of being dizzy and sustained abrasions on her face and arms and had a reddened area on her forehead.</p> <p>A review of the facility policy titled, Abuse Prevention Program, dated August 2021, indicated, .Our residents have the right to be free from abuse .Protect our residents from abuse by anyone including, but not necessarily limited to .facility staff .or any other individual .Require staff training/orientation programs that include such topics as .handling verbally or physically aggressive resident behavior .</p>		