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 10/29/2024
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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46145 Based on interview and record review, facility staff failed to document a resident assessment, leading to the downgrading of monitoring (decreasing level of monitoring resident by staff) from 1:1 (one staff member monitors one resident) to behavior watch every 15 minutes, for one of 10 sampled residents (Resident 1). This failure had the potential to not accurately reflect the resident's current condition and the rationale for downgrading their monitoring level, leading to a gap in the continuity of care. Findings: On October 28, 2024, at 12:50 p.m., an unannounced visit was made to the facility for a facility reported resident-to-resident altercation issue. A review of Resident 1 ' s medical records, titled, Face sheet, dated, October 15, 2024, at 10:12 (am/pm not indicated), indicated, resident was admitted to the facility on [DATE], with a diagnosis of schizophrenia (a mental disorder that affects thought, behaviors, and feelings). Further review of Resident 1's Minimum Data Set (an assessment tool) indicated, Resident 1 had a Brief Interview for Mental Status (cognitive/memory assessment) score of 15 (cognitively intact). A review of Resident 1 ' s progress notes titled, Behavior Note, dated October 14, 2024, at 7:30 p.m., indicated, . (at approximately 6:15 p.m.) while lying down in the side courtyard, (Resident 1) was hit with a ball that was kicked by peer. (Resident 1) walked over to peer and slapped peer twice . (Resident 1) placed on 1:1monitoring . A review of Resident 1 ' s monitoring sheets, dated October 14, 2024, indicated, . Physical aggression towards peer, placed on 1:1 monitoring at 6:15 p.m., thru 10:00 p.m. Further review of Resident 1's monitoring sheets indicated Resident 1 was downgraded to behavior watch every 15 minutes (BWQ15) monitoring at 10:00 pm. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1 ' s progress notes, indicated, no documented behavioral assessment of Resident 1 on October 14, 2024, leading to monitoring downgrade from 1:1 to BWQ15. Further review, indicated, a progress notes, dated October 15, 2024, at 6:18 a.m., . (Resident 1) continues on BWQ15 monitoring . (related to) altercation with . peer . On October 28, 2024, at 4:00 p.m., an interview was conducted with Program Manager (PM) 1, who stated, the procedure for managing an aggressor in a resident-to-resident altercation is to place the resident on 1:1 behavior precaution monitoring for their safety and the safety of others. PM 1 stated, residents on 1:1 monitoring remain on a 1:1 until assessed by nursing or PMs. PM 1 stated, if the assessment showed the resident was no longer exhibiting aggresive behaviors, the monitoring would be downgraded to behavior watch every 15 minutes. PM 1 further stated, a progress note of the resident ' s assessment should be documented in the resident ' s medical record. On October 28, 2024, at 4:30 p.m., a concurrent interview with the Director of Nursing (DON), and review of Resident 1's Monitoring Sheets and progress notes dated, October 14 & 15, 2024, were conducted. The DON stated, the process to downgrade behavioral monitoring from 1:1 to BWQ15, required a behavioral assessment by nursing or PM, followed by a progress note documenting the assessment. The DON verified, Resident 1's monitoring was downgraded from 1:1 to BWQ15 on October 14, 2024, at 10:00 p.m., and a behavioral assessment was not documented in Resident 1's progress notes and it should have been. The DON stated, the licensed nurse should document a resident 's behavioral assessment when downgrading the monitoring level, because it communicates the resident ' s behaviors at the time of the downgrade. On October 29, 2024, at 3:39 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1, who stated, the process to downgrade a resident 's behavioral monitoring included a nursing assessment of the resident ' s current behaviors. LVN 1 stated, if the resident was assessed as no longer being aggressive towards peers, the monitoring would be downgraded from 1:1 to BWQ15. LVN 1 verified, she was the nurse who assessed Resident 1 on October 14, 2024, and downgraded their monitoring from 1:1 to BWQ15 at 10 p. m. LVN 1 further stated, she had forgotten to document her assessment in Resident 1 's progress notes. A facility Policy & Procedure, titled, Behavioral Assessment and Monitoring, undated, indicated, . Behavioral Precautions monitoring is staff assessment and observation of the client 's status on a continuous (1:1) basis. It is enacted to monitor client behavior when clients have demonstrated a significant change in behavior that places themselves or other(s) at high risk for harmful behaviors. Behavior Precautions ensures that direct care staff (are) present with the client at all times to provide constant observations . The period for Behavior Precautions monitoring ranges from a few minutes up to 72 hours . The monitoring is in place until the client can demonstrate control and verbalize a willingness to not engage in harmful behavior towards self or others . Nursing and or Program is required to document the initial behavioral episode at the time the incident occurred . Behavior Precautions status will be review (sic) by Nursing or Program staff daily . Supportive documentation by nursing or program in the client record is required when discontinuing Behavior Precautions .