

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  11/07/2024
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44505</b></p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the California Department of Public Health (CDPH) immediately, and no later than two hours after the allegation was made, for two of five residents reviewed for abuse (Residents 12 and 80).</p> <p>This failure had the potential to delay the implementation of appropriate action and protective measures for the residents, placing them at risk for further abuse.</p> <p>Findings:</p> <p>On November 7, 2024, a review of Resident 80's Admission Record, indicated, Resident 80 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (a mental health condition).</p> <p>A review of Resident 80's History and Physical, dated July 16, 2024, indicated, Resident 80 had the capacity to understand and make decisions.</p> <p>A review of Resident 80's Progress Notes, dated November 2, 2024, indicated, .The Change In Condition/s reported .It was reported to this nurse that while on the courtyard during a group, (Resident 80) asked a female peer (Resident 12) to return her batteries/radio she had loaned to her. The peer refused. (Resident 80) grabbed for her radio/batteries and the peer (Resident 12) held onto the radio and began to bite (Resident 80) on her right hand through her jacket .</p> <p>On November 6, 2024, at 1:38 p.m., during an interview with Resident 80, Resident 80 stated, last Saturday (November 2, 2024), she asked Resident 12 for the radio that Resident 12 borrowed from her. Resident 80 further stated, Resident 12 did not want to give it back, so she tried to take it and Resident 12 tried to bite her on the arm. Resident 80 stated a staff witnessed the incident.</p> <p>A review of Resident 12's Admission Record, indicated Resident 12 was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder, bipolar type (a mental health condition where a person is expressing symptoms of both schizophrenia [hearing voices, or seeing things that are not there] and bioplar disorder [with episodes of feeling overly energetic or irritable and feeling very sad, hopeless, or lacking energy]).</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 12's Progress Notes, dated November 2, 2024, indicated, .The Change in Condition/s reported .On the courtyard during a group, a female peer (Resident 80) asked (Resident 12) to return the batteries/radio she had loaned. (Resident 12) refused; the female peer grabbed for the radio/batteries and (Resident 12) held onto it and began to bite the female peer (Resident 80) .</p> <p>A review of facility document regarding reporting of Suspected Dependent Adult/ Elder Abuse, dated November 2, 2024, indicated, .Resident 12 held onto the radio and then bit Resident 80 on the hand through her jacket .</p> <p>On November 6, 2024, at 10:50 a.m., during an interview with Resident 12, Resident 12 stated, she tried to bite someone, but did not know who.</p> <p>On November 6, 2024, at 2:05p.m., during an interview with the Assistant Activities Director (AAD), the AAD stated, on Saturday, November 2, 2024, Resident 80 attempted to grab the radio from Resident 12, and Resident 12 bit Resident 80 on her right arm.</p> <p>On November 7, 2024, at 8:45 a.m., during a concurrent interview and review of Resident 80's progress notes dated November 2, 2024, with Registered Nurse (RN1), RN 1 stated Resident 80 and Resident 12 had a physical altercation on November 2, 2024. RN 1 stated she did not report the incident to CDPH since it occurred over the weekend.</p> <p>On November 7, 2024, at 9:50 a.m., during an interview with the Administrator (Admin), the Admin stated, the staff should report any reportable resident to resident altercation to CDPH, by phone and fax, even on the weekend.</p> <p>On November 7, 2024, at 10:53 a.m., during an interview with the Director of Nursing (DON), the DON stated, the timeline to report to CDPH is within 2 hours, for patient safety and to prevent further abuse.</p> <p>A review of the facility Policy and Procedure titled, Abuse Procedure, Client to Client Abuse Procedure, undated, indicated, .call in to report to LTC Ombudsman/ Law Enforcement and CDPH within 2 hours. Fax completed (abuse report) form to LTC Ombudsman, Law Enforcement and CDPH preferably by end of shift and no longer than 24 hours .</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>50309</p> <p>Based on observation, interview, and record review, the facility failed to ensure dietary staff were able to carry out the functions of food and nutrition services safely and effectively when:</p> <ol style="list-style-type: none"> <li>[NAME] 1 (CK) 1 did not check the cooking temperature for beef patties, fish, and chicken tenders during lunch meal preparation on November 5, 2024;</li> <li>Dietary staff did not follow manufacturer's guidelines for testing the red bucket sanitizer;</li> <li>Four dietary staff did not follow the facility food preparation and cleaning procedure of surfaces and stationary equipment;</li> <li>One Dietary Aide did not know the right concentration of the red bucket sanitize; and</li> <li>One Dietary Aide did not know the right location and could not demonstrate the correct procedure to test for dish sanitization.</li> </ol> <p>These failures had the potential to cause food borne illness (stomach illness acquired from ingesting contaminated food) to the residents in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>On November 5, 2024, at 10:42 a.m., an observation was conducted with CK 1. CK 1 was observed removing a platter of cooked beef patties from oven without checking the cooking temperature.</li> </ol> <p>On November 5, 2024, at 10:50 a.m., an observation was conducted with CK 1. CK 1 was observed removing a platter of cooked chicken tenders and cooked fish from oven without checking the cooking temperature.</p> <p>On November 5, 2024, at 11:34 a.m., during an interview with CK 1, CK 1 stated she forgot to check the cooking temperatures of the beef patties, fish, and chicken tenders. She stated a temperature guide had been posted on the wall and she should have checked the temperature and referred to it. CK 1 further stated checking the temperature ensured the meats were fully cooked and at a safe serving temperature to prevent the potential for foodborne illness.</p> <p>On November 6, 2024, at 2:10 p.m., an interview was conducted with the Registered Dietitian (RD), the RD stated it was standard practice to check the temperature of meat after cooking to ensure minimum cooking temperature had been reached and the food had been cooked in a safe manner. The RD further stated, if the meat had not been cooked thoroughly, it could have resulted in foodborne illness for residents who had received food from the kitchen.</p> <p>A review of facility provided recipe titled, Hamburger: Beef/Veal, dated 2024, indicated, .Internal temperature (temp) of cooked patties should register at least 160 degrees Fahrenheit ( F - a unit of measurement) for 15 seconds at completion of cooking .</p> <p>(continued on next page)</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review facility provided recipe titled, Baked Fish Fillet, dated 2024, indicated, .Internal temperature of cooked fish should register at least 145 degrees F for 15 seconds at the end of cooking time .</p> <p>A review facility provided recipe titled, Chicken Tenders, dated 2002-2024, indicated, .Internal temperature of finished product must register at least 165 degrees F at completion of cooking time .</p> <p>During a review of the facility provided job description titled Cook, the job description indicated, .Position Summary .to prepare food in accordance with current applicable federal, state and local standards .Essential Duties and Responsibilities .following menus and recipes .adhering to all facility policies and procedures of the facility .</p> <p>2. During a review of the Quaternary Ammonium sanitizer (Quat - sanitizing solution used for sanitizing food contact surfaces and used equipment) test strip bottle's instructions indicated, .Dip paper in quat solution .for 10 seconds .</p> <p>On November 5, 2024, at 10:56 a.m., a concurrent observation and interview were conducted with CK 2. CK 2 was observed demonstrating how to check the Quat sanitizer in the red bucket. CK 2 placed the test strip in the red bucket Quat sanitizer for 4 seconds. CK 2 stated she should have kept the test strip in the bucket for 10 seconds, according to the test kit instructions, to avoid cross contamination and prevent stomach issues to the residents.</p> <p>On November 5, 2024, at 11:21 a.m., a concurrent observation and interview were conducted with Dietary Aide (DA) 1. DA 1 was observed demonstrating how to check Quat sanitizer in the red bucket. DA1 placed the test strip in the red bucket for 6 seconds. DA 1 stated she should have kept the test strip in the bucket for 10 seconds according to the manufacturer's guidelines, to prevent cross-contamination.</p> <p>On November 5, 2024, at 12:09 p.m., a concurrent observation and interview was conducted with DA 2. DA 2 was observed demonstrating how to check the Quat sanitizer in the red bucket. DA 2 placed the test strip in the red bucket for 15 seconds. DA 2 stated she should have kept the test strip in the bucket for 10 seconds according to the manufacturer's guidelines. DA 2 further stated, not having the correct solution concentration could cause cross contamination and food borne illness to the residents.</p> <p>On November 5, 2024, at 12:19 p.m., an interview was conducted with DA 3. DA 3 stated the process for checking the Quat sanitizer in the red bucket. DA 3 stated she would place the test trip in the Quat sanitizer for 15 seconds. DA 3 stated she had not been following the proper sanitizing process and should have been placing the test strip in the sanitizer for 10 seconds. DA 3 further stated, the solution concentration should be correct to prevent food borne illness.</p> <p>On November 6, 2024, at 2:10 p.m., an interview was conducted with the RD. The RD stated the Quat sanitizer test strip should be dipped for 10 seconds as per the manufacturer's instructions. The RD further explained if the concentration of the sanitizing solution was not prepared properly, it could result in food borne illness to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility provided job description titled Dietary Aide, the job description indicated, . Position Summary .to provide assistance in all functions in accordance with current applicable federal, state and local standards that govern the facility and as directed by the Dietary or other management .Essential Duties and Responsibilities .adhering to sanitation and food safety guidelines during meal preparation and clean up .</p> <p>A review of U.S. FDA (Food and Drug Administration) Food Code 2022, Section 4-501.114 Manual and Mechanical Ware washing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness, indicated, .(C) A quaternary ammonium compound solution shall (2) Have a concentration as specified under S 7-204.11 and as indicated by the manufacturer's use directions included in the labeling .</p> <p>3. During a review of U.S. FDA Food Code 2022, Section 4-603.15 Washing, Procedures for Alternative Manual Warewashing Equipment, indicated, .Some pieces of equipment are fixed or too large to be cleaned in a sink. Nonetheless, cleaning of such equipment requires the application of cleaners for the removal of soil and rinsing for the removal of abrasive and cleaning chemicals, followed by sanitization .</p> <p>During a review of U.S. FDA Food Code 2022, Section 4-701.10 Food-Contact Surfaces and Utensils, the food code indicated, Effective sanitization procedures destroy organisms of public health importance that may be present on wiping cloths, food equipment, or utensils after cleaning, or which have been introduced into the rinse solution. It is important that surfaces be clean before being sanitized to allow the sanitizer to achieve its maximum benefit.</p> <p>On November 5, 2024, at 11:34 a.m., an interview was conducted with CK 1. CK 1 stated the process for cleaning used food preparation surfaces and stationary equipment was to use the green bucket which contained a mixture of bleach and soap solution, and then sanitize with Quat sanitizer.</p> <p>On November 5, 2024, at 12:02 p.m., an interview was conducted with DA 4. DA 4 stated the process for cleaning used food preparation surfaces and stationary equipment was to use soap and then sanitize with Quat sanitizer.</p> <p>On November 5, 2024, at 12:07 p.m., an interview was conducted with DA 1. DA 1 stated the process for cleaning used food preparation surfaces and stationary equipment was to use soap from the green bucket and then sanitize with the Quat sanitizer in the red bucket.</p> <p>On November 5, 2024, at 12:19 p.m., an interview was conducted with DA 3. DA 3 stated the process for cleaning used food preparation surfaces and stationary equipment was to use soap first and then sanitize with Quat sanitizer.</p> <p>On November 6, 2024, at 2:10 p.m., an interview was conducted with the RD. The RD stated the proper steps to clean used food preparation surfaces and stationary kitchen equipment was to first wash soap and water in the green buckets, rinse in between with water, and then sanitize with the sanitizing solution in the red buckets. The RD further stated, if these steps were not followed, there could be potential cross-contamination which could result in food borne illness for residents who receive food from the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On November 5, 2024, at 12:09 p.m., a concurrent observation and interview of the Quat sanitizing test with DA 2, DA 2 placed the test strip in the red bucket Quat sanitizer for 15 seconds and then compared the test strip color with the color chart on the test strip kit. DA 2 stated the blue green color of the test strip indicated the correct concentration which should be within the 400-500 parts per million (ppm - a unit measurement) range. DA 2 stated she did not follow the manufacturer's guidelines and should have double checked the concentration range. She stated, the correct concentration should show a yellow green color and be within the 200 ppm range. DA 2 further stated, if the solution did not have the proper concentration, it could lead to cross contamination and foodborne illness.</p> <p>On November 6, 2024, at 2:10 p.m., an interview was conducted with the RD. The RD stated the correct concentration of the Quat sanitizer solution in the red bucket should be within 200 ppm, according to the manufacturer's instructions. The RD stated the dietary staff were expected to follow the guidelines to ensure proper sanitization testing and to prevent food borne illness for the residents.</p> <p>During a review of the sanitizer manufacturer's instructions titled, Contact Surface Sanitization Directions, indicated, .To sanitize pre cleaned and potable water rinsed .contact surfaces .prepare 200-400 ppm active quaternary ammonium solution .</p> <p>During a review of the facility provided job description titled Dietary Aide, the job description indicated, . Position Summary .to provide assistance in all functions in accordance with current applicable federal, state and local standards that govern the facility and as directed by the Dietary or other management .Essential Duties and Responsibilities .adhering to sanitation and food safety guidelines during meal preparation and clean up .</p> <p>5. On November 5, 2024, at 12:09 p.m., a concurrent observation and interview of the dish machine was conducted with DA 2, DA 2 placed the test strip inside the water compartment to test for the chlorine sanitation level. She stated this was the correct location to check the concentration of the sanitizer in the dish machine. DA 2 then compared the test strip with the color chart on the test strip kit and stated the range should be within 100-200 ppm. DA stated, she should have confirmed with her supervisor the proper location to test, and she should have double checked the manufacturer's guidelines for the accurate range. DA 2 further stated, not following the manufacturer's guidelines could result in the dish machine not sanitizing properly which could lead to foodborne illness.</p> <p>On November 6, 2024, at 2:10 p.m., an interview was conducted with the RD. The RD stated the right location to check the concentration of the chlorine sanitizer of the dish machine was to place the test strip directly on the top surface of the kitchenware that was just cleaned, not in the water compartment. The RD stated, placing the test strip in the wrong location would not give an accurate reading, and the dish machine may not have the correct chlorine sanitizer concentration which could result in the kitchenware not being properly sanitized. The RD further stated, the dish machine rinse should provide 50 ppm on the dish surface and if the staff did not follow the proper testing procedure, the kitchenware might not be sanitized properly, potentially resulting in cross-contamination and food borne illness for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility policy and procedure titled, Section F: Safety and Sanitation, dated 2020, indicated, . Daily Chlorine Testing Station, indicated, .X .Ware washing .Policy .utensils, dishes, beverage containers, pots and pans, flatware used for the preparation, service, or storage of food will be cleaned and sanitized after each use .Procedure .A .Low temp machine .rinse must provide 50 ppm hypochlorite (chlorine) on the dish surface .</p> <p>During a review of the facility provided job description titled Dietary Aide, the job description indicated, . Position Summary .to provide assistance in all functions in accordance with current applicable federal, state and local standards that govern the facility and as directed by the Dietary or other management .Essential Duties and Responsibilities .adhering to sanitation and food safety guidelines during meal preparation and clean up .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50309</p> <p>Based on observation, interview, and record reviews, the facility failed to maintain a sanitary environment, prepare, and serve food in accordance with professional standards for food service safety when:</p> <ol style="list-style-type: none"> <li>1. The two-compartment preparation sink (sink used for preparing foods) did not have an air gap (a vertical space between the end of a pipe and the top of a nearby sink that prevents the backflow of contaminated water);</li> <li>2. Six out of six white storage shelves in the reach-in refrigerator labeled number 2, were found to have peeled chipped paint.</li> <li>3. Three drying rack shelves (one near the handwashing sink and two by the side doorway kitchen entrance) were found to be worn and with brown grime.</li> <li>4. One unlabeled cooking oil was stored in a water pitcher found in the kitchen;</li> <li>5. Two cutting boards with deep indentations were found in the kitchen; and</li> <li>6. Dust was found on storage shelves inside the dietary storage room and on drying racks.</li> </ol> <p>These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) among the residents in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of the professional reference U.S. FDA (Food and Drug Administration) Food Code 2022, Section ,d+[DATE].14 Backflow Prevention Device, indicated, .A plumbing system shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the food establishment .backflow prevention is required by law, by: (A) Providing an air gap .; or (B) Installing an approved backflow prevention device .</li> </ol> <p>On [DATE], at 11:29 a.m., a concurrent observation in the kitchen and interview were conducted with the Dietetic Services Supervisor (DSS). A two-compartment preparation sink was observed in the kitchen without an air gap. The DSS stated dietary staff used the two-compartment sink for preparing food and there was no air gap. He further stated, the sink should have an air gap to prevent contamination of the water supply and the potential for foodborne illness among the residents.</p> <p>On [DATE], at 2:10 p.m., an interview was conducted with the Registered Dietitian (RD), the RD stated she was unaware of the regulation requiring an air gap for the preparation sink.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. On [DATE], at 10:27 a.m., a concurrent observation and interview in the kitchen with the DSS, six of six white shelves inside the reach-in refrigerator number 2 had chipped coating, exposing brown metal. The DSS stated the chipped coating on the six shelves was worn out and should be replaced to avoid the metal corrosion, which could contaminate kitchenware or food and lead to foodborne illness.</p> <p>On [DATE], at 2:10 p.m., an interview was conducted with the RD. The RD stated the shelves in the reach-in refrigerator should not have any chipped coating and should be replaced. The RD further stated, the shelves should not have corrosion to avoid cross-contamination and prevent food borne illness.</p> <p>3. On [DATE], at 9:51 a.m., a concurrent observation and interview was conducted with the DSS in the kitchen. A drying rack was observed with shelves covered in brown grime. The DSS verified the shelves had brown grime and were worn out and could potentially cause cross-contamination to the kitchen equipment being dried on them.</p> <p>On [DATE], at 11:21 a.m., a concurrent observation and interview was conducted with the DSS in the kitchen near the side doorway. Two drying racks were observed with shelves covered in brown grime. The DSS confirmed the shelves had brown grime and stated the drying rack shelves were worn out. The DSS stated worn-out shelves could potentially cause cross contamination to the kitchen equipment being dried on them.</p> <p>On [DATE], at 2:10 p.m., a concurrent observation and interview were conducted with the RD. After checking the drying rack shelves (one near the handwashing sink and two by the side doorway kitchen entrance), the RD stated the drying racks should not have any grime and they should be replaced to prevent cross contamination and avoid food borne illness.</p> <p>A review of the facility policy and procedure titled, Sanitization, dated [DATE], indicated, .All .shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrossions .</p> <p>4. On [DATE], at 2:27 p.m., during a concurrent observation and interview in the kitchen with the DSS and CK 3, an unlabeled clear water pitcher containing yellow liquid was found on the countertop. The DSS could not identify the yellow liquid inside the pitcher. CK 3 stated, the yellow liquid was cooking oil and he should have placed a label on it. CK 3 stated he should have labeled the pitcher with its contents and the use-by date to avoid passing the expiration date and preventing food borne illness to the residents.</p> <p>On [DATE], at 2:10 p.m., an interview was conducted with the RD. The RD stated it was not a good practice to store liquids in an unlabeled pitcher. She stated all kitchen items not stored in their original containers should be labeled with the name of the contents, along with the opened and used-by dates. The RD further stated, unlabeled containers with no use-by dates could lead to the use of expired ingredients, causing foodborne illness to the residents.</p> <p>A review of the facility policy and procedure titled, Labeling and Dating of Food, dated [DATE], indicated, .All food will be dated, labeled, and prepared for storage to prevent contamination .opened products that cannot be stored in their original containers must be transferred to a plastic re-usable container and covered .the product should be clearly labeled and dated .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the U.S FDA Food Code 2022, Section ,d+[DATE].12 Food Storage Containers, Identified with Common Name of Food, indicated, .Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food .</p> <p>5. During a review of the U.S FDA Food Code 2022, Section ,d+[DATE].12 Cutting Surfaces, indicated, . Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces .</p> <p>On [DATE], at 3:15 p.m., a concurrent observation and interview was conducted with the DSS in the kitchen. Two cutting boards (brown and white color with measuring at 15 centimeters [(a unit measurement of length)] in width and 20 cm in length) were observed with deep indentations and a rough surface. The DSS stated the cutting boards had indentations and should have a smooth surface to prevent microorganisms (germs) from growing in the grooves and cause food borne illness for residents.</p> <p>6. On [DATE], at 11:21 a.m., during a concurrent observation and interview with the DSS in the kitchen near the side doorway kitchen entrance, two drying rack's shelves were found to have brown debris. The DSS stated the brown debris was dust.</p> <p>On [DATE], at 3:35 p.m., during a concurrent observation and interview with the DSS in the dietary storage room, multiple shelves were found with brown debris. The DSS stated the shelves had not been cleaned and should be cleaned to prevent contamination which can lead to food borne illness.</p> <p>On [DATE], at 2:10 p.m., an interview was conducted with the RD, the RD stated the shelves should always be kept clean and there should not be any dust in the kitchen. The RD further stated this could result in an unsanitary environment and cross contamination to the food in the storage room and kitchen.</p> <p>A review of the facility policy and procedure titled, Safety and Sanitization, dated 2020, indicated, .Employee responsibility for safety .Storage areas .shelves will be kept clean .Storage areas will be kept clean and free of clutter .</p>

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  11/07/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51063</p> <p>Based on observation, interview, and record review, the facility failed to ensure four pill cutters (equipment used to cut medications) were cleaned before being stored in the medication carts (equipment used to store and dispense medications).</p> <p>This failure had the potential to result in cross contamination (transfer of microorganism (germs) from one object to another) of medications which could lead to infection.</p> <p>Findings:</p> <p>On November 6, 2024, at 10:30 a.m., during a concurrent observation of the afternoon (PM) medication cart in nursing station 2 and an interview with the Licensed Psychiatric Technician (LPT), two blue pill cutters had green -brown grime buildup and white powder residue. The LPT stated the pill cutters should be cleaned between uses, and replaced or thrown when dirty. The LPT stated the two pill cutters were dirty and had medication residue. The LPT stated, she did not know when it was last cleaned. The LPT stated the pill cutters should have been cleaned and should not have been left in the medication cart, readily available for use, as this could cause cross contamination of resident medications and could lead to infection.</p> <p>On November 6, 2024, at 11:16 a.m., during a concurrent observation of the AM (morning) and PM medication carts in nursing station 1 (one) and an interview with the Assistant Director of Nursing (ADON), two blue pill cutters had white powder residue. The ADON stated the two pill cutters were dirty and had medication residue. The ADON further stated the pill cutters should have been cleaned or thrown away to prevent cross-contamination which could lead to infection.</p> <p>On November 6, 2024, at 2:06 p.m., during an interview with the Infection Preventionist (IP), she stated the facility medication carts should contain clean equipment for medication administration and any dirty equipment should be thrown away to prevent cross contamination which could lead to infection. The IP further stated pill cutters should be cleaned after each use and changed as needed when dirty. The IP stated the four dirty pill cutters should have been thrown away and not left in the medication carts, readily available for use.</p> <p>A review of the facility policy and procedure titled, Equipment and Supplies for Administering Medications, dated April 2008, indicated, .The medication nurse on duty ensures that equipment and supplies relating to medication administration are clean and orderly .</p> <p>A review of the facility policy and procedure titled, Infection Control, dated October 2018, indicated, .The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infection .</p>		