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	11/06/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the dietary staff followed the manufacturer's instructions for testing the Quaternary (quaternary ammonium compounds [quats] are a group of chemicals used as disinfectants) sanitizer. This failure had the potential to result in inaccurate readings of the sanitizing solution, which could lead to cross-contamination. Findings:On November 4, 2025, at 3:38 p.m., during an observation of a Dietary Aide (DA) testing the sanitizing solution, the DA was observed dipping the Quat strip into the sanitizing solution for six seconds before comparing the strip to the color comparator chart.In a concurrent interview with the DA, the DA stated the manufacturer's instructions indicated the strip should be dipped for one to two seconds then compare to the comparator chart within 10 seconds. The DA stated she should have followed the instruction. The DA further stated that failure to follow them could result in inaccurate reading. On November 4, 2025, at 4:09 p.m., during an observation of the Cook, the [NAME] was observed testing the sanitizing solution. The [NAME] was observed dipping the quaternary test strip into the solution for ten seconds before comparing it to the color comparator chart. In a concurrent interview with the Cook, the [NAME] stated the instructions indicated the strip should be dipped for one to two seconds and compared to the comparator chart within 10 seconds. The [NAME] stated she should have followed the instruction. The [NAME] further stated improper testing could result in an inaccurate reading.On November 6, 2025, at 3:01 p.m., during an interview with the Dietary Service Supervisor (DSS), the DSS stated, when the chemical sanitizer was not tested according to the manufacturer's instruction, the reading would be inaccurate and had the potential to lead to cross-contamination.A review of the facility In-service for Quaternary Testing, dated May 21, 2025, indicated .Please refer to the product label for complete direction for use.A review of the facility's Testing Strips for sanitizing solution Manufacturer's instruction indicated the following:1. 1. Dip strip into solution to be tested for 1-2 seconds, then 2. Compare strip to color chart within 10 seconds .

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician-ordered therapeutic diets were followed for three of nine residents (Residents 65, 53, and 32). Each of these residents, who were ordered a low cholesterol -low fat diet were served creamy noodles instead of parsley noodles as specified on the therapeutic menu.These failures had the potential to result in increased cholesterol levels and compromised nutritional status for these residents.Findings:On November 6, 2025, the facility document titled Fall 2025 menu, for lunch was reviewed. The document indicated:-Regular diet- 2 oz. baked chicken; creamed noodles; 1 bread slice; 1 square banana foster cake; and 8 oz water. -Low fat /Low cholesterol diet - baked chicken; parsley noodles; parsley carrots; 1 bread slice; 1 square banana foster cake; and 8 oz water.On November 6, 2025, at 12:15 p.m., during lunch observation and a concurrent interview with the Dietary Supervisor (DS), Resident 65 was served with creamed noodles. The DS stated Resident 65 was on a low cholesterol, low fat diet and should have been served parsley noodles.A review of Resident 65's admission Record indicated Resident 65 was admitted to the facility on [DATE], with diagnoses which included Hyperlipidemia (very high levels of fats in the blood).A review of Resident 65's Physician's order, dated November 5, 2024, indicated . Low Fat/Low Cholesterol Diet. On November 6, 2025, at 12:35 p.m., during lunch observation and a concurrent interview with the DS, the DS stated, Resident 53 was served creamed noodles instead of parsley noodles. The DS stated Resident 53 had an order for a low cholesterol, low fat diet.A review of Resident 53's admission Record indicated Resident 53 was admitted to the facility on [DATE], with diagnoses which included Hyperlipidemia (very high levels of fats in the blood).A review of Resident 53's Physician's order, dated November 5, 2024, indicated . Low Fat/Low Cholesterol Diet. On November 6, 2025, at 12:52 p.m., during lunch observation and a concurrent interview with the DS, Resident 32 was served creamed noodles. The DS stated Resident 32 was supposed to receive parsley noodles instead of creamed noodles. The DS stated she should have been provided with parsley noodles consistent with low cholesterol, low fat diet. A review of Resident 32's admission Record indicated Resident 32 was admitted to the facility on [DATE], with diagnoses which included Hyperlipidemia (very high levels of fats in the blood).A review of Resident 32's History and Physical dated November 4, 2025, indicated .Resident 32 has the capacity to understand and make decisions . A review of Resident 32's Physician's order, dated November 5, 2024, indicated . Low Fat/Low Cholesterol Diet. On November 6, 2025, at 3:01 p.m., during an interview with the Registered Dietician (RD), the RD stated, dietary staff should follow the physician-ordered therapeutic diets. The RD stated failure to follow a low fat/low cholesterol diet had the potential to increase cholesterol levels for Residents 65, 53 & 32.During a review of the facility's policy and procedure titled, Therapeutic Diets, dated October 2017, indicated, .Therapeutic diets are prescribed by the Attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consistently monitor and document resident's highest level of pain as ordered by the physician, for one of two residents reviewed for pain (Resident 15). This failure had the potential for the resident to experience pain and discomfort, which could negatively impact physical and mental well-being. Findings:On November 3, 2025, at 10:21 a.m., an interview was conducted with Resident 15. Resident 15 was alert, observed to be walking in the hallway. Resident 15 stated he experienced headaches and received pain medication but that it was not provided consistently.A review of Resident 15's record was conducted. Resident 15 was admitted [DATE], with diagnosis including schizoaffective disorder (a mental disorder), and gastro-esophageal reflux (overproduction of acids in digestive system).The History and Physical dated July 1, 2025, indicated Resident 15 had the capacity to understand and make decisions.A review of Resident 15's Change in Condition dated October 1, 2025, indicated, .client report of sudden lower back pain.provider recommendations give Tylenol (pain medication) 20ml PO (by mouth) Q6h (every six hours) x 14 day (for 14 days).and monitor.A review of Resident 15's care plans indicated no care plan was developed to address the current pain management needs, despite multiple documented episodes of pain requiring PRN (as needed) medication.A review of Resident 15's Medication Administration Review (MAR) for October 2025 to November 2025, showed the following documented pain level associated with PRN pain medication administration: -October 1, 2025, at 11:04 p.m. - pain level 5.-October 2, 2025, at 2:05 p.m. - pain level 7.-October 6, 2025, at 12:14 a.m. - pain level 7.-October 29, 2025, at 10:31 p.m. - pain level 3-November 2, 2025, at 10:32 p.m. - pain level 4A review of Resident 15's pain monitoring section of the MAR for October 1, 2, 6, 29, 2025 and November 2, 2025, indicated that the highest pain level for each shift was documented as 0 for every shift, including shifts where PRN pain medication had been administered for pain levels above zero. There was no documented evidence that the physician's order to monitor the highest pain level every shift was followed on five occasions when pain medication was administered.A review of Resident 15's Weekly Nursing Progress Note, indicated:-Dated October 29, 2025, indicated, .pain.(No) .checked.highest pain level.(blank).-Dated November 5, 2025, indicated, .pain.(No) .checked.highest pain level.(blank).The weekly nursing notes did not reflect the pain documented on the MAR for October 29 to November 2, 2025.A review of Resident 15's Order Summary Report for the month of November 2025, indicated the following: -Acetaminophen Oral Liquid, give 20 ml (milliliters - a unit of measure) by mouth every 6 hours as needed for pain for 14 days.- MONITOR FOR PAIN LEVEL 0-10 (a scale to measure pain level) every shift for pain.- MONITOR FOR HIGHEST PAIN LEVEL 0-10 every shift for pain.On November 5, 2025, at 2:34 p.m., an interview was conducted with Licensed Psychiatric Technician (LPT 1). LPT 1 stated she administered pain medication to Resident 15 on November 4, 2025. LPT 1 stated she completed a pain assessment before administering the medication and documented a pain score. LPT 1 stated the pain score documented during medication administration should match the pain score recorded for the shift, so that the highest pain level for the shift is accurately captured. On November 5, 2025, at 3:53 p.m., a concurrent interview and record review was conducted with LPT 2. LPT 2 stated, he provided pain medication for Resident 15 on October 29, 2025, and November 2, 2025. LPT 2 stated, he documented a pain score at the time of medication administration and followed up to assess effectiveness. LPT 2 stated, he did not document the highest pain level for the shift, as required by the physician's order. LPT 2 stated, he should have documented the pain level for the shift so that accurate monitoring could occur. On November 6, 2025, at 2:26 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated all residents receiving pain medication as needed or routine should have a care plan addressing pain. The DSD stated Resident 15 did not have a pain management care plan and the weekly assessments should have included the highest pain level, which was missing for the dates pain medication was administered. A review of the facility policy and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure titled, Pain Assessment and Management, dated October 2022, indicated, .Pain management is a multidisciplinary care process that includes.developing and implementing approaches to pain management.monitoring for the effectiveness of interventions.assessing pain.monitor the resident for the presence of pain and the need for further assessment when there is a change of condition.assess pain using a consistent approach.monitor the resident's pain.each shift for acute pain or significant changes in levels.documentation.document the reported pain level of pain with adequate detail in accordance with the pain management program.the person conducting the assessment shall record the information obtained from the assessment in the resident's medical record.