STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555017	A. Building B. Wing	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverwalk Post Acute	4000 Harrison Street Riverside, CA 92503

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41348 Based on interview, and record review, the facility failed to ensure the call lights (devices that emit a tone and light up indicating the location of the call, used by the residents to signal a need for assistance from facility staff), were answered timely, when four out of four residents (Residents 1, 2, 3, and 4), who required assistance from staff with activities of daily living (ADLs), verbalized their concerns of facility staff not answering their call lights and/or attending to their needs in a timely manner. This failure had the potential for delayed medical management and unmet care needs. Findings: On December 15, 2023, at 10:40 a.m., an unannounced visit was conducted at the facility for two linked complaints. On December 15, 2023, at 11:10 a.m., Resident 1 was observed dressed, sitting on the edge of his bed. During a concurrent interview, Resident 1 stated he had been at the facility for about one month. Resident 1 stated it could take up to one hour or longer for call light response. Resident 1 stated he would sit in soiled briefs (adult diaper) while waiting for the call light to be answered. On December 15, 2023, at 11:17 a.m., Resident 2 was observed lying in bed. During a concurrent interview, Resident 2 stated she had been at the facility for about three years. Resident 2 stated call light response could be up to one hour. Resident 2 stated the morning shift was better at answering call lights, but it varied depending on staff providing care. Resident 2 stated her only concern at the facility was call light response. On December 15, 2023, at 11:20 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated call lights should be answered as soon as possible. CNA 1 stated it was unacceptable for residents to wait an hour to have their needs met. CNA 1 stated when busy assisting other residents, the CNA should explain to the resident that they were needed else where and return as soon as possible. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 15, 2023, at 11:27 a.m., Resident 3 was observed dressed sitting in a wheelchair beside her bed. During a concurrent interview, Resident 3 stated she had been at the facility about three years. Resident 3 stated call light response time varied, and she had waited over an hour for staff to come to help her. Resident 3 stated her only concerns at the facility was call light response time. On December 15, 2023, at 1:40 p.m., Resident 4 was observed lying in bed. Resident 4 stated he had been at the facility for a few weeks. Resident 4 stated the staff did not answer call lights timely and could take up to one hour for a response. Resident 4 stated he would call for assistance when he had a soiled brief and would sit dirty for too long until staff came. On December 15, 2023, at 1:55 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated call lights were all staff ' s responsibility, not just the CNAs. LVN 1 stated call lights should be answered timely, and residents should not have to wait an hour to have their needs met. LVN 1 stated when call lights were not answered timely residents could have a fall or have an increased risk of skin breakdown due to sitting in soiled briefs too long. On December 15, 2023, at 2:04 p.m., an interview was conducted with CNA 2. CNA 2 stated call lights should be answered within five minutes. CNA 2 stated all staff were responsible to answer resident call lights. CNA 2 stated when call lights were not answered timely residents could fall. CNA 2 stated soiled briefs could lead to skin breakdown if left unattended too long. On December 15, 2023, at 2:06 p.m., an interview was conducted with CNA 3. CNA 3 stated call lights should be answered as soon as possible to prevent falls. CNA 3 stated all staff were responsible to answer the resident call lights. CNA 3 stated accidents could occur, and urinary tract infections (UTIs) could increase when soiled briefs were not changed timely. CNA 3 stated residents should not wait an hour to have their call light answered. On December 15, 2023, at 2:10 p.m., an interview was conducted with CNA 4. CNA 4 stated all staff should help with the call lights. CNA 4 stated it was unacceptable for residents to wait an hour to have their call lights answered. CNA 4 stated for some residents they would push the call light and then state it had been an hour for response, when actually it was 15 minutes, but residents may attempt to get up and fall when the call light was not answered timely. CNA 4 stated call lights needed to be answered as soon as possible. On December 15, 2023, Resident 1 ' s record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included fracture of the right femur (leg bone), sepsis (infection of the blood that can cause organ failure), diabetes mellitus (abnormal sugar in the blood) and history of falling. Review of Resident 1 ' s Physician History and Physical indicated resident had capacity to make decisions. Resident 2 ' s record was reviewed. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included transient cerebral ischemic attacks (TIA ' s-stroke that only lasts for a few minutes, occurs when blood supply to the brain is cut off briefly), muscle weakness, and hemiplegia/hemiparesis (paralysis of one side of the body). Review of Resident 2 ' s Physician History and Physical indicated Resident 2 had capacity to make decisions. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3 ' s record was reviewed. Resident 3 was admitted to the facility on [DATE], with diagnoses which included muscle wasting, diabetes mellitus, shortness of breath, and muscle weakness. Review of Resident 3 ' s Physician History and Physical indicated Resident 3 had capacity to make decisions. Resident 4 ' s record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses which included muscle wasting, epilepsy (injury in the brain that can cause seizures), diabetes mellitus, sepsis, and history of brain cancer. Review of Resident 4 ' s Physician History and Physical indicated Resident 4 had fluctuating capacity to make decisions. On December 15, 2023, at 2:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated call lights should be answered timely and residents should not have to wait to prevent accidents. Review of the facility policy titled, Answering the Call Light revised October 2010, indicated, .The purpose of this procedure is to respond to the resident ' s request and needs .Answer the resident ' s call as soon as possible .If you have promised the resident you will return .do so promptly . Review of the facility policy titled, Activities of Daily Living (ADLs), Supporting revised March 2018, indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .