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	07/11/2024

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48870 Based on interview and record review, the facility failed to document that the discharge from the facility was necessary for one of three sampled residents (Resident 4), even after Resident 4 was cleared and the psychiatric hold was discontinued during hospitalization . This failure has the potential to negatively affect the resident's psychosocial well-being, who considered the facility as her home. Findings: On [DATE], at 11:45 a.m., an unannounced visit was conducted to investigate issues of Admission, Transfer and Discharge Rights. A review of Resident 4's medical record on [DATE], indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included spinal tumor resection, hemiplegia (paralysis) and hemiparesis (weakness on one side of the body), major depressive disorder (persistent low mood), and generalized anxiety disorder (excessive, uncontrollable worry). A review of records indicated a Notice of proposed 30- day discharge, dated [DATE], was effective the same day it was provided to the resident. The notice indicated the resident will be discharged to a board and care or preferred setting. A review of Resident 4 ' s records titled, Notice of Transfer/ Discharge, dated [DATE], indicated the transfer was effective on [DATE], and the resident would be transferred to the general acute care hospital (GACH) due to the needs of the resident could not be met at the facility. A review of the medical record indicated Resident 4 was sent to the hospital for a psychiatric evaluation and a 5150 hold on [DATE]. The medical record further indicated there was a physician ' s order to transfer Resident 4 for treatment of violent and aggressive behaviors on [DATE]. Further review of Resident 4's records indicated the discharge to the board and care or preferred setting for [DATE], did not push thru since the resident was transferred to the GACH the same day for psychiatric evaluation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident 4 ' s Interdisciplinary Team Meeting (IDT), dated [DATE], indicated, Per H&P, Resident has capacity to make decisions. (FULL CODE) No Advanced Directives in place at the moment, however previously offered. IDT members met with resident to conduct a care plan meeting. IDT members proceeded to introduce themselves and each department involved in meeting. Resident proceeded to play Spanish music on her IPAD device. Administrator informed resident of meeting, informed resident due to her previous incidents with her electric wheelchair on [DATE], the facility will provide a regular wheelchair to prevent anymore incidents with other residents or staff members, for safety purposes. Administrator provided resident with a 30-day notice and informed resident the process of 30-day notice and also options for discharges. Resident refused to sign notice and stated in Spanish, I will leave before the time, All because of this son of a bitch. you stupid black bitch. No wonder your mother died . Resident was referring to DON. Throughout discussion resident refused to acknowledge or listen to administrator, continued to play Spanish music. Administrator informed resident she was issued a ,d+[DATE] order per psychiatrist to evaluate her. Resident was disrespectful towards IDT members and stated in Spanish Everyone is stupid. Resident had no questions at the time. IDT members will continue to follow up with resident, as needed. During an interview on [DATE], at 2:10 pm, with the Director of Nursing (DON) and Administrator, they stated Resident 4 has been abusive toward everyone in the facility since admission and they have tried to redirect and provide interventions as ordered without effect. On [DATE], the facility provided a 30-day discharge notice to Resident 4 and obtained orders to transfer Resident 4 to the hospital for a psychiatric evaluation after the resident refused to speak with the psychiatrist in the facility. On [DATE], at 2:30 p.m., during an interview, the Social Services Director (SSD), stated after the hospital cleared Resident 4 to return to the facility, the facility did not issue a new Notice of Discharge to Resident 4 or the Ombudsman. On [DATE], at 2:50 p.m. during an interview, the Psychiatrist stated Resident 4 was abusive and would refused to seek help or treatment for the behavioral issues, despite multiple attempts by facility staff to stop violent behavior. On [DATE], at 3:45 p.m., during an interview, the Discharge Planner (DP) stated the only Notice of Discharge provided to Resident 4 was the initial 30-day Notice of Discharge. ([DATE], the day of transfer to the GACH). A review of the GACH record dated [DATE], indicated, .Psychiatrist assessed patient and discontinued psychiatric legal hold. No longer on a psychiatric hold .Psychiatrist considers patient ' s symptoms to be more medically related . (Skilled Nursing Facility name) has informed that the patient is unable to return back due to ongoing behavior for the last 3-years . A review of facility records did not indicate the facility re-evaluated the resident's current behavior or condition after the resident was cleared and was no longer on psychiatric legal hold at the GACH, to ascertain whether the facility would not be able to provide same level of care provided at the GACH, or the same level of care provided to the resident prior to the GACH hospitalization . A review of Resident 4's records did not indicate a written documentation justifying why the resident was discharged and not permitted to return to the skilled nursing facility (SNF) after a therapeutic hospitalization . (continued on next page)

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy and procedure titled, Transfer or Discharge Notice, dated [DATE], indicated, . Residents are permitted to stay in the facility and not be transferred or discharged unless .the transfer is necessary for the resident ' s welfare and the resident ' s needs cannot be met in the facility .Under the following circumstances .notice is given as soon as it is practicable but before the transfer or discharge .the safety of individuals in the facility would be endangered .the health of individuals in the facility would be endangered .if the information in the notice changes prior to the transfer or discharge, the recipients of the notice are updated as soon as possible . Review of the facility policy and procedure titled, Bed-Holds and Returns, dated [DATE], indicated, .If the facility determines that a resident cannot return, the facility must comply with the requirements for facility-initiated discharges .Residents are not discharged unless . the resident ' s clinical or behavioral status endangers the safety of individuals in the facility .the resident ' s clinical or behavioral status endangers the health of individuals in the facility .Following a hospitalization , residents whom staff are concerned about permitting to return due to their clinical/behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred .

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48870 Based on interview and record review the facility failed to provide a notice of discharge for one of three sampled residents (Resident 4), when the facility made the determination not to accept the resident back to the facility while the resident was still at the general acute care hospital (GACH). In addition, the facility failed to provide a copy of Resident 4's updated notice of discharge to the representative of the Office of the State Long Term Care (LTC) Ombudsman. These failures had the potential for the resident and the resident's representative not to fully understand the reason for not being able to return to the facility which was her home since 2015; and could delay the Ombudsman in advocating for the resident. Findings: A review of Resident 4's medical record on June 26, 2024, indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included spinal tumor resection, hemiplegia (paralysis) and hemiparesis (weakness on one side of the body), major depressive disorder (persistent low mood), and generalized anxiety disorder (excessive, uncontrollable worry). A review of records indicated a Notice of proposed 30- day discharge date d June 18, 2024, with the effective of the same day was provided to the resident. The notice indicated the resident will be discharged to a board and care or preferred setting. A review of Resident 4' records titled, Notice of Transfer/ Discharge, dated June 18, 2024, indicated the transfer was effective on June 18, 2024, and the resident would be transferred to the GACH due to the needs of the resident could not be met at the facility. A review of the physician's order dated June 18, 2024, indicated, .May transfer to [Name of Hospital] for psychiatrist (a doctor who diagnoses and treats mental, emotional, and behavioral disorders) evaluation per [Name of Doctor] order . On June 27, 2024, at 2:10 p.m., during an interview, the Administrator stated he told the Long-Term Care Ombudsman the facility was not going to readmit the resident. The Administrator stated the facility sent the Notice of Transfer and the 30-day Notice of Discharge to the Ombudsman. On July 11, 2024, at 2:30 p.m., during an interview, the Social Service Director (SSD), stated the Discharge Planner (DP) was responsible for sending out the notice of discharge and notifying the ombudsman for any resident transfer/discharge. The SSD stated a second Notice of Transfer/Discharge was not completed after Resident 4 was seen and treated at the hospital. The SSD stated the facility practice was to notify the Ombudsman of resident transfer or discharge as soon as practicable or within 72 hours. She stated the only notice sent to the Ombudsman was on the day Resident 4 was transferred to the hospital (June 18, 2024). (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 11, 2024, at 3:25 p.m., during an interview, the Director of Nursing (DON) stated she has not received any updates from the hospital and did not send a second Notice of Transfer/Discharge to the ombudsman. The DON stated that the only discharge notice provided to the resident and the ombudsman was the 30-Day Notice of Discharge, dated June 18, 2024. On July 11, 2024, at 3:45 p.m., during an interview, the DP stated she only sent one Notice of Transfer to the ombudsman, which was when Resident 4 was transferred to the GACH. She stated if an updated Notice of Transfer/Discharge needs to be sent when the resident was discharged while the resident is at the hospital, the SSD must complete the form and send the notification to the Ombudsman. During an interview on July 11, 2024, at 4:00 p.m., the Marketing Director (MD) stated she spoke with two of the case managers at the hospital, and explained the reasons the facility was not readmitting Resident 4 and offered placement assistance. The MD stated she did not send an updated Notice of Transfer/Discharge to the ombudsman. A review of the GACH record dated June 20, 2024, indicated, .Psychiatrist assessed patient and discontinued psychiatric legal hold. No longer on a psychiatric hold .Psychiatrist considers patient's symptoms to be more medically related . (Skilled Nursing Facility name) has informed that the patient is unable to return back due to ongoing behavior for the last 3-years . A review of Resident 4's record did not indicate whether a new notice of discharge was provided to the resident or the Ombudsman when the resident was discharged and determined not to be readmitted back to the facility after the resident's psychiatric hold was discontinued at the GACH. A review of the facility's policy and procedure titled, Transfer or Discharge Notice, dated March 2021, indicated, .Under the following circumstances, the notice is given as soon as practicable but before the the transfer or discharge: a. The safety of individuals in the facility would be endangered, b. The health of individuals in the facility would be endangered .5. A copy of the notice is sent to the State Long Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and the representative .8. If the information in the notice changes prior to the transfer or discharge, the recipients of the notice are updated as soon as practicable .

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48870 Based on interview, and record review, the facility failed to provide a notice of bed-hold for one of three residents (Resident 4) reviewed, upon transfer to the acute care hospital. Resident 4 was transferred to the acute care hospital on June 18, 2024. This failure resulted in Resident 4 not being aware of the bed-hold policy of the facility. In addition, this failure resulted in the resident not to be aware of her rights to be allowed to go back to the facility. Findings: On June 26, 2024, at 11:45 a.m., an unannounced visit to the facility was conducted to investigate an admission, transfer, and discharge issue. A review of Resident 4's record indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included diagnoses including major depressive disorder (all-encompassing low mood) and generalized anxiety disorder (long lasting anxiety). A review of the progress notes dated June 18, 2024, indicated, . Patient is seen for a comprehensive psychiatric evaluation at request of facility due to aggressive behavior and making threats .Despite unstable mood and increasing aggression, pt (patient) refuses all psychiatry services and psychotropic medication. Pt most recently had incident with staff and another resident, threatening the life and safety of others. Due to immediate risk for harm to others, pt placed on 5150 hold DTO. Per staff report, pt has become increasingly more aggressive and hostile with staff and other residents. Pt had incident with another resident and threatened life and safety. Pt unwilling to engage with staff or providers with failed attempts at redirecting and de-escalation. Pt is unpredictable and immediate danger to others . A review of Resident 4' records titled, Notice of Transfer/ Discharge, dated June 18, 2024, indicated the transfer was effective on June 18, 2024, and the resident would be transferred to the GACH due to the needs of the resident could not be met at the facility. A review of the physician's order dated June 18, 2024, indicated, .May transfer to [Name of Hospital] for psychiatrist (a doctor who diagnoses and treats mental, emotional, and behavioral disorders) evaluation per [Name of Doctor] order . There was no documented evidence that Resident 4 was provided a notice of bed-hold. On July 11, 2024, at 9:30 a.m., during an interview with the Social Services Director (SSD), the SSD stated Resident 4 should have a bed-hold on file because that is her right as a resident. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 11, 2024, at 2:20 p.m., during an interview with the Director of Nursing (DON), the DON stated Resident 4 was not offered a bed hold because she was transferred out as a 5150 for danger to others and the facility had already issued Resident 4 a 30-day Notice of Discharge due to behavioral concerns. On July 11, 2024, at 4:05 p.m. during an interview with the DON, the DON stated she was not aware of the requirement to issue Resident 4 a notice of bed hold, there was no order for bed hold from the physician. A review of the facility policy titled, Bed-Holds and Returns , dated October 2022, indicated, .All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave) .The requirement that residents be permitted to return to the facility following hospitalization .applies to all residents .

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48870 Based on interview and record review, the facility failed to ensure one of three sampled residents' (Resident 4) clinical behavior or condition was re-evaluated for re-admission to the facility after a therapeutic hospitalization . Resident 4 was cleared and the psychiatric hold was discontinued on [DATE], but was refused re-admission at the facility. This failure had the potential for Resident 4 not to be provided the opportunity to return to the facility she considered home since 2015, which could negatively affect the psycho social well-being of Resident 4. Findings: On [DATE], at 11:45 a.m., an unannounced visit was conducted to investigate issues of Admission, Transfer and Discharge Rights. A review of Resident 4's medical record on [DATE], indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included spinal tumor resection, hemiplegia (paralysis) and hemiparesis (weakness on one side of the body), major depressive disorder (persistent low mood), and generalized anxiety disorder (excessive, uncontrollable worry). A review of records indicated a Notice of proposed 30- day discharge, dated [DATE], was effective the same day it was provided to the resident. The notice indicated the resident will be discharged to a board and care or preferred setting. A review of Resident 4's records titled, Notice of Transfer/ Discharge, dated [DATE], indicated the transfer was effective on [DATE], and the resident would be transferred to the general acute care hospital (GACH) due to the needs of the resident could not be met at the facility. A review of the medical record indicated Resident 4 was sent to the hospital for a psychiatric evaluation and a 5150 hold on [DATE]. The medical record further indicated there was a physician's order to transfer Resident 4 for treatment of violent and aggressive behaviors on [DATE]. Further review of Resident 4's records indicated the discharge to the board and care or preferred setting for [DATE], did not push thru since the resident was transferred to the GACH the same day for psychiatric evaluation. (continued on next page)

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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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident 4 ' s Interdisciplinary Team Meeting (IDT) , dated [DATE], indicated, Per H&P, Resident has capacity to make decisions. (FULL CODE) No Advanced Directives in place at the moment, however previously offered. IDT members met with resident to conduct a care plan meeting. IDT members proceeded to introduce themselves and each department involved in meeting. Resident proceeded to play Spanish music on her IPAD device. Administrator informed resident of meeting, informed resident due to her previous incidents with her electric wheelchair on [DATE], the facility will provide a regular wheelchair to prevent anymore incidents with other residents or staff members, for safety purposes. Administrator provided resident with a 30-day notice and informed resident the process of 30-day notice and also options for discharges. Resident refused to sign notice and stated in Spanish, I will leave before the time, All because of this son of a bitch. you stupid black bitch. No wonder your mother died . Resident was referring to DON. Throughout discussion resident refused to acknowledge or listen to administrator, continued to play Spanish music. Administrator informed resident she was issued a ,d+[DATE] order per psychiatrist to evaluate her. Resident was disrespectful towards IDT members and stated in Spanish Everyone is stupid. Resident had no questions at the time. IDT members will continue to follow up with resident, as needed. On [DATE], at 2:10 p.m., during an interview, the Administrator stated he received a phone call from the Ombudsman the day after Resident 4 was transferred to [Name of Hospital] and told the Ombudsman the facility had no intention of readmitting Resident 4 back into the facility due to Resident 4's violent, aggressive, non-compliant behaviors towards others. The Administrator stated he was trying to protect the other residents from further harm. On [DATE], at 2:30 p.m., during an interview, the Social Services Director (SSD), stated after the hospital cleared Resident 4 to return to the facility, the facility did not issue a new Notice of Discharge to Resident 4 or the Ombudsman. On [DATE], at 2:50 p.m. during an interview, the Psychiatrist stated Resident 4 was abusive and would refused to seek help or treatment for the behavioral issues, despite multiple attempts by facility staff to stop violent behavior. On [DATE], at 3:45 p.m., during an interview, the Discharge Planner (DP) stated the only Notice of Discharge provided to Resident 4 was the initial 30-day Notice of Discharge. ([DATE], the day of transfer to the GACH). A review of the GACH record dated [DATE], indicated, .Psychiatrist assessed patient and discontinued psychiatric legal hold. No longer on a psychiatric hold .Psychiatrist considers patient's symptoms to be more medically related . (Skilled Nursing Facility name) has informed that the patient is unable to return back due to ongoing behavior for the last 3-years . A review of facility records did not indicate the facility re-evaluated the resident's current behavior or condition after the resident was cleared and was no longer on psychiatric legal hold at the GACH, to ascertain whether the facility would not be able to provide same level of care provided at the GACH, or the same level of care provided to the resident prior to the GACH hospitalization . A review of Resident 4's records did not indicate a written documentation justifying why the resident was not permitted to return after a therapeutic hospitalization . (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy and procedure titled, Transfer or Discharge Notice , dated [DATE], indicated, . Residents are permitted to stay in the facility and not be transferred or discharged unless .the transfer is necessary for the resident's welfare and the resident's needs cannot be met in the facility .Under the following circumstances .notice is given as soon as it is practicable but before the transfer or discharge .the safety of individuals in the facility would be endangered .the health of individuals in the facility would be endangered .if the information in the notice changes prior to the transfer or discharge, the recipients of the notice are updated as soon as possible . Review of the facility policy and procedure titled, Bed-Holds and Returns , dated [DATE], indicated, .If the facility determines that a resident cannot return, the facility must comply with the requirements for facility-initiated discharges .Residents are not discharged unless . the resident's clinical or behavioral status endangers the safety of individuals in the facility .the resident's clinical or behavioral status endangers the health of individuals in the facility .Following a hospitalization , residents whom staff are concerned about permitting to return due to their clinical/behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred .