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	11/01/2024

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 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** 48240 Based on interview and record review, the facility failed to ensure the medical record was complete, for one of one resident, Resident 1, when a care conference meeting was not documented in the medical record. This failure had the potential to impact Resident 1 ' s plan of care by not having a clear understanding of the resident ' s needs, preferences, and any changes in the care plan. In addition, this failure had the potential to create miscommunication among the care team, Resident 1, and Resident 1 ' s caregiver. Findings: On November 1, 2024, at 9:55 a.m., an unannounced visit was conducted at the facility to investigate a complaint. On November 1, 2024, a review of Resident 1's medical record indicated she was admitted to the facility on [DATE], with diagnoses which included fracture of the right tibia (shinbone), mild intellectual disability and cerebral palsy (a group of neurological disorder that permanently affect body movement and muscle coordination). A review of Resident 1's History and Physical dated September 8, 2024, indicated she was .alert and oriented x 4. Follows commands . Resident 1 was discharged to (name of board and care) on October 29, 2024. On November 1, 2024, at 2:42 p.m., during an interview with Licensed Vocational Nurse (LVN) 1, who was also the Minimum Data Set Nurse, LVN 1 stated care conferences are conducted quarterly and are documented in PointClickCare (PCC-an electronic health record). LVN 1 stated they conducted a care conference for Resident 1, but she could not recall the exact date. A record review of Resident 1 ' s medical record was conducted with LVN 1. LVN 1 stated the care conference was not documented. LVN 1 stated during care conferences she writes her notes on paper then will transfer it later to PCC. LVN 1 stated the SSD (Social Service Director) will open the care conference note in PCC and then the rest of the interdisciplinary team (IDT- a group of professionals who plan, coordinate, and deliver personalized health care) members, who attended the meeting will document their notes after. (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

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On November 1, 2024, at 4:33 p.m., during an interview with the Director of Nursing (DON), the DON stated care conferences were scheduled with residents and families to discuss their concerns, problems, diet, diagnosis, discharge planning and to give an update on the resident ' s current condition. The DON stated care conferences should be documented. When the DON was asked to review if Resident 1 ' s care conference was documented on PCC, the DON asked the Assistant Director of Nursing (ADON) to review it. The ADON stated care conferences were conducted five days after admission and it should be documented in PCC. The ADON stated there was no documented care conference notes in PCC. The ADON stated the SSD opens the care conference note in PCC on the day of the conference and the last IDT member to document, locks the note. On November 6, 2024, at 2:44 p.m., during an interview with the SSD, the SSD stated the care conference for Resident 1 was conducted on September 13, 2024, via telephone call. The SSD stated Resident 1 ' s caregiver and the Administrator of (name of board and care) where Resident 1 lived, attended the care conference. The SSD stated she was responsible for opening the care conference note but she was not able to open it. On November 12, 2024, at 2:55 p.m., during a follow up telephone interview with the DON, the DON stated the facility did not have a policy about care conferences being documented. The DON stated she expected the IDT members to document the care conferences because if it was not documented, then it was not done.