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	12/24/2024

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on observation, interview, and record review, the facility failed to follow its policy and procedure for prevention of pressure injuries, for one of two residents, Resident 1, when a dressing (a covering put on a wound to protect it while it heals) was placed on Resident 1's right hip and no further assessment or follow up was conducted. After removal of the dressing, Resident 1 was found to have an unstageable pressure injury (a sore that is covered by slough [tan, yellow or green debris] or eschar [thick black or brown scab or crust]) to his right hip. This failure resulted in Resident 1's wound to not be properly assessed and treated. Findings: A review of Resident 1's medical records indicated the following: a. Resident 1 was admitted to the facility on [DATE], with diagnoses including cerebral palsy (a chronic condition that affects a person's ability to move and maintain balance and posture) and unspecified local infection of the skin and subcutaneous (beneath or under, all the layers of the skin) tissue. b. Resident 1's History and Physical dated September 19, 2024, indicated he did not have the capacity to understand and make decisions. c. Resident 1's care plan titled Skin initiated on September 19, 2024, indicated he was at risk for developing skin breakdown and interventions included .Check skin daily during care provisions . d. Resident 1's BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK dated October 4, 2024, indicated he had moderate risk for developing a pressure injury. A review of Resident 1's Order Summary and Treatment Administration Record (TAR) for the period of November 1 to December 18, 2024, indicated he received treatment for a surgical wound on his back. Further review of Resident's 1 medical record indicated there was no other documented evidence that Resident 1 had other skin problems. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On December 18, 2024, at 12:12 p.m., during an interview with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 1 had a wound on his right hip and right lower back. CNA 1 stated when she provided care to Resident 1 last week, both areas were covered with a dressing. CNA 1 further stated if the wound was covered with a dressing it was being treated. On December 18, 2024, at 12:39 p.m., during a concurrent interview and record review of Resident 1's medical record with Treatment Nurse (TN) 1, TN 1 stated if a resident has a skin problem, she will evaluate the resident, notify the resident and family, and notify the resident's medical doctor to obtain a treatment order. TN 1 stated Resident 1 was admitted with an abscess (enclosed collection of pus in tissues, organs, or confined spaces in the body) on his right lower back which was being treated and the resident was being followed by a wound specialist weekly. TN 1 stated Resident 1 did not have any other wounds. On December 18, 2024, at 1:00 p.m., during an observation of Resident 1 with CNA 1 and TN 1, Resident 1 was observed with a wound on his right lower back covered with a brown dressing, a pimple-like skin condition in his midline back that was uncovered, and a brown dressing over his right hip. TN 1 was asked to remove the dressing from the right hip. Resident 1 had a yellow wound on his right hip about the size of a pencil eraser. The skin around the wound was pale in color. TN 1 stated it was the first time she had seen the wound on Resident 1's right hip. On December 18, 2024, at 1:30 p.m., during a follow up interview with TN 1, TN 1 stated Resident 1's wound on his right hip was identified when they did the wound rounds with the wound nurse practitioner earlier that morning, and they put a dressing over it. TN 1 stated Resident 1's wound on the right hip had slough on it so she will classify it as an unstageable pressure injury. A review of Resident 1's (name of wound specialist) Progress Note dated December 18, 2024, indicated there was no documentation Resident 1's wound on the right hip was addressed. A review of Resident 1's Order Summary Report indicated, .Treatment: R (right) Hip- Cleanse w/ (with) NS (normal saline - salt water), pat dry, apply honey paste (medical-grade honey), and cover w/ dry dressing every day shift for unstageable pressure injury for 14 Days . was ordered on December 19, 2024. On December 30, 2024, at 4:01 p.m., during a telephone interview, TN 2 stated the following: a. The CNAs notified her when residents have new skin problems. She also checks the residents' skin while providing treatment. b. She applies foam dressings to the resident's skin problem that could develop into wounds. c. When a resident has an actual wound, she contacts the doctor for a treatment order and documents it. d. Only the licensed nurses are allowed to apply dressings over wounds. e. If a resident has a dressing on, it could either be for padding or for treating a wound. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. She applied foam dressings to Resident 1's right arm, right knee, and right hip two days after he had a fall (October 31, 2024), because she noticed Resident 1 was leaning on his right side when he was up in his wheelchair, causing friction. She informed the CNAs and licensed nurses about the foam dressings she applied to Resident 1 and to notify her for any changes. g. She was not aware of Resident 1 having any wound on his right hip. h. She should have obtained a doctor's order to apply the foam dressing as padding to avoid missed skin issues and to prevent confusion among the nurses. On January 2, 2024, at 1:59 p.m., during a telephone interview with the Director of Nursing (DON), the DON stated TN 2 informed her that she placed a foam dressing over Resident 1's right hip on December 17, 2024, because a CNA reported skin redness and that TN 2 informed the other treatment nurses because she would be off duty. The DON stated when the TNs or licensed nurses received a report that a resident has skin redness, she expected them to assess the resident's skin, notify the medical doctor, write a treatment order in the resident's medical record, and notify the other licensed nurses or herself (DON) when they do not have enough time to complete it. A review of the facility's policy and procedure dated April 2020 titled Prevention of Pressure Injuries indicated .Inspect the skin on a daily basis when performing or assisting with personal care or ADLs .identify any signs of developing pressure injuries .inspect pressure points .evaluate, report and document potential changes in the skin .