

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Riverwalk Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on interview and record review, the facility failed to ensure for one of two residents, Resident 1, the power of attorney (POA-someone who is legally authorized to act on the resident's behalf) was notified when Resident 1 ' s physician ordered lorazepam (an anti-anxiety medication). This failure resulted in Resident 1 ' s POA to be unaware of his overall condition. Findings: On February 21, 2024, at 3:09 p.m., during an interview with Resident 1 ' s POA, the POA stated Resident 1 was administered lorazepam, and she was not notified about it. On March 3, 4, and 5, 2025, unannounced visits were conducted at the facility. A review of Resident 1 ' s medical record indicated he was admitted to the facility on [DATE], with diagnoses which included obstructive uropathy (blockage of urine flow) and he had a POA. A review of Resident 1 ' s Nurse ' s Note dated November 22, 2024, written by Licensed Vocational Nurse (LVN) 1, indicated, Received new order from MD (medical doctor) for resident to start Ativan (lorazepam) for anxiety and restlessness. Also gave order for psych eval. Orders noted and carried out, communicated with staff . A review of Resident 1 ' s Physician ' s Orders indicated .LoRazepam Tablet 1 MG Give 1 tablet by mouth every 4 hours as needed for anxiety . was ordered on November 22, 2024. There was no documented evidence that Resident 1 ' s POA was notified of the physician ' s orders on November 22, 2024. On March 5, 2025, at 1:13 p.m., during an interview with LVN 2 and record review of Resident 1 ' s medical record, LVN 2 stated the resident and his or her representative should be notified for all changes in condition and any new orders. LVN 2 stated there was no documented evidence in Resident 1 ' s medical record that the POA was notified of the physician ' s orders on November 22, 2024. On March 5, 2025, at 3:40 p.m., during an interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), the DON stated LVN 2 should have notified the POA when she received the orders for lorazepam. (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 12, 2025, at 2:20 p.m., during a telephone interview, Licensed Vocational Nurse (LVN) 1 stated she could not recall Resident 1. LVN 1 stated she was at the facility, and she was asked to review Resident 1 ' s medical record. LVN 1 stated she wrote a progress note on November 22, 2024, indicating she received new orders of lorazepam. LVN 1 stated she could not recall if she notified Resident 1 ' s POA about the orders. A review of the facility ' s policy and procedure titled, Resident Representative dated February 2021, indicated, .The resident representative has the right to exercise the resident ' s rights to the extent those rights are delegated to the representative .The facility will treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or authorized by the resident (in accordance with applicable laws) . A review of the facility ' s policy and procedure titled, Change in a Resident ' s Condition or Status dated February 2021, indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) .		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240 Based on observation, interview, and record review, the facility failed to ensure, weight loss for two of three residents reviewed was evaluated (Residents 1 and 2). This failure had the potential for Residents 2 and 3 to experience further weight loss and not have their nutritional needs met. Findings: On March 3, 4, and 5, 2025, unannounced visits were conducted at the facility. A review of Resident 1 ' s medical record indicated he was admitted to the facility on [DATE], with diagnoses which included obstructive uropathy (a condition in which the flow of urine is blocked). A review of Resident 1 ' s care plan titled Malnutrition: Resident is at risk for malnutrition . initiated on November 19, 2024, included interventions which included .Notify the physician of weight loss .Refer to RD (Registered Dietician) as needed . A review of Resident 1 ' s Weights tab in PointClickCare (an electronic health care software) indicated Resident 1 weighed: a. 168 lbs. (pounds - unit of measurement) on November 20, 2024. This entry was crossed out on January 9, 2025; b. 153 lbs. on December 4, 2024 (total weight loss of 15 lbs. or 8.9% for two weeks); c. 150 lbs. on December 17, 2024; d. 155 lbs. on December 23, 2024; and e. 151 lbs. on January 8, 2025. A review of Resident 1 ' s NUTRITIONAL RISK ASSESSMENT (ADMISSION/ANNUAL) completed by the RD, dated November 25, 2024, indicated Resident 1 weighed 168 lbs. on November 20, 2024, and his usual body weight was 170 lbs. There was no documented evidence that Resident 1 ' s physician or the RD was notified of Resident 1 ' s weight loss of 15 lbs. or 8.9% on December 4, 2024. In addition, there was no documented evidence that interventions for weight loss were initiated. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 4, 2025, at 11:06 a.m., during an interview, the Restorative Nurse Assistant (RNA) stated the RNAs obtained the weight of the residents in the facility upon admission then weekly for four weeks then monthly. The RNA stated if a resident was noted with weight loss, the resident ' s weight was monitored weekly again for two to three weeks. The RNA stated when she noted there is weight loss, she notifies Licensed Vocational Nurse (LVN) 3, the Assistant Director of Nursing (ADON) and Director of Nursing (DON). On March 5, 2025, at 3:15 p.m., during a telephone interview, the RD stated she was familiar with Resident 1. The RD stated Resident 1 was underweight when he was admitted . The RD stated she did not believe that Resident 1 weighed 168 lbs. on admission and that the weight may have been referenced from the hospital which can be inaccurate. The RD stated she assessed Resident 1 on November 25, 2025, and made recommendations because he was already underweight. The RD stated she struck out his weight on admission because it was an outlier and after monitoring Resident 1 ' s weight for four weeks, he weighed between 150 to 155 lbs. On March 5, 2025, at 3:40 p.m., during an interview with the ADON and DON, the ADON stated she documented Resident 1 ' s weight on November 20, 2025, of 168 lbs. because that was the information provided to her by the RNA. The ADON reviewed Resident 1 ' s GACH (general acute care hospital) notes and she stated Resident 1 weighed 170 lbs. on November 13, 2024 (7 days before Resident 1 ' s weight was obtained at the facility). The ADON stated Resident 1 had a 15-lb. weight loss between November 20, 2024, and December 4, 2024. The ADON and DON stated they did not know why the RD crossed out Resident 1 ' s initial weight of 168 lbs. The DON stated the RD should not have struck it out without letting her know. On March 5, 2025, at 4:37 p.m., the DON called the RD on speaker phone. The DON asked the RD about Resident 1 ' s weight. The RD stated she struck out the weight because Resident 1 will continue to falsely trigger for weight loss. 2. A review of Resident 2 ' s medical record indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (high blood sugar level). A review of Resident 2 ' s Physician History and Physical dated February 6, 2025, indicated he had the capacity to make decisions. A review of Resident 2 ' s Weights tab in PointClickCare (an electronic health care software) indicated Resident 2 weighed: a. 225 lbs. on February 6, 2025; b. 200 lbs. on February 18, 2025 (total weight loss of 25 lbs. or 11% for two weeks); c. 191 lbs. on February 25, 2025; and d. 184 lbs. on March 5, 2025. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 3, 2025, at 1:10 p.m., during an interview, LVN 3 stated Resident 3 was admitted with edema (a condition where excess fluid accumulates in the body's tissues, causing swelling) on both legs. LVN 3 stated Resident 2 had 25 lb. weight loss on February 18, 2025, and she notified the Physician ' s Assistant verbally, but she did not document. LVN 3 further stated a change of condition report, monitoring every shift for 72 hours, and a care plan for Resident 2 should have been initiated on February 18, 2025. On March 3, 2025, at 2:11 p.m., during a concurrent observation and interview, Resident 2 was in his room, sitting in bed and he was alert and conversant. Resident 2 stated he was aware that he was losing weight because the staff told him about his weight during the weigh-ins. Resident 2 stated both of his legs were swollen after hospitalization . Resident 2 was asked why he was losing weight, he stated he was not eating all his food because the food at the facility tasted different from home. Resident 2 stated no one had spoken to him about his weight loss or any plan regarding his nutrition. On March 5, 2025, at 3:15 p.m., during a telephone interview, the RD stated she was notified of Resident 2 ' s weight loss on February 18, 2025. She was informed that Resident 2 would be re-weighed but no one updated her. There was no documented evidence that Resident 2 ' s physician was notified of the weight loss and no documentation that interventions for weight loss were initiated. On March 5, 2025, at 3:40 p.m., during an interview with the ADON and DON, the ADON stated Resident 2 had a 25-lb. weight loss between February 6, 2025, and February 18, 2025, and the physician and the family should have been notified and that Resident 2 should have been monitored as well. A review of the facility ' s policy and procedure titled Weight Assessment and Intervention, dated March 2022 indicated .Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation .If the weight is verified, nursing will immediately notify the dietitian in writing .		