

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 06/20/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an antihypertensive medication was held in accordance with the physician order for one of two sampled residents (Resident 1). In addition, the facility facility failed to ensure the physician was notified that Resident 1's antihypertensive medication was not administered in accordance with the physician order.</p> <p>These failures had the potential to negatively affect the resident's medical condition.</p> <p>Findings:</p> <p>On July 19, 2025, at 10:36 a.m., during an interview, Resident 1 stated a nurse did not give her blood pressure (BP) medication last week.</p> <p>A review of Resident 1's admission Record, indicated she was admitted to the facility on [DATE], with diagnoses which included hypertension (HTN-high blood pressure).</p> <p>A review of Resident 1's History and Physical, dated May 5, 2025, indicated the resident had decision-making capacity.</p> <p>A review of Resident 1's Order Summary Report, dated June 19, 2025, indicated, Losartan Potassium-HCTZ (losartan-hctz &ndash; a BP medication) Tablet 50-12.5 MG Give 1 tablet by mouth one time a day for HTN Hold if SBP (systolic blood pressure) less than 110 or pulse less than 60 . was ordered on April 28, 2025.</p> <p>A review of Resident 1's Medication Administration Record (MAR), for the month of June 2025 indicated that on June 12, 2025, at 9:00 a.m., Resident 1's SBP was 119 and losartan was held due to vital signs outside of parameter.</p> <p>Further review of Resident 1's medical record indicated there was no documented evidence that Resident 1's physician was notified when LVN 1 held Resident 1's losartan-hctz.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On June 19, 2025, at 1:39 p.m., during a concurrent interview with Licensed Vocational Nurse (LVN) 1 and record review of Resident 1's MAR for the month of June 2025, LVN 1 stated a resident's blood pressure was held depending on the parameter ordered by the physician and depending on the resident's condition. LVN 1 stated she would hold blood pressure medication when a resident SBP is less than 120 to avoid the resident's blood pressure to go low. LVN 1 stated she was familiar with Resident 1, and she held the losartan once last week because her SBP was less than 120. LVN 1 stated she did not want her blood pressure to drop. LVN 1 stated the physician's order was to hold Resident 1's losartan if SBP was less than 110. When LVN 1 was asked if she followed the physician's order, LVN 1 stated she used her nursing judgement because Resident 1's SBP was low.</p> <p>On June 20, 2025, at 11:21 a.m., during a concurrent interview with the Director of Nursing (DON) and a record review of Resident 1's MAR for the month of June 2025, the DON stated blood pressure medications are held depending on what the physician's order was, if the order indicated to hold if SBP is less than 110 then the licensed nurses should hold the blood pressure medication. The DON stated LVN 1 did not follow the physician's order. The DON stated there was no documentation on July 12, 2025, that LVN 1 notified the Resident 1's physician that she held the losartan.</p> <p>On June 20, 2025, at 12:30 p.m., the DON stated that they do not have a specific policy on holding blood pressure medications but that if she was LVN 1 she would have written a progress note and notified Resident 1's physician that she held the losartan when her SBP was 119.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food in accordance with the physician's order for one of two sampled residents (Resident 1).</p> <p>This failure has the potential to result in poor intake, leading to weight loss.</p> <p>Findings:</p> <p>On July 19, 2025, at 10:36 a.m., during interview, Resident 1 stated she was allergic to gluten (a protein found in the wheat plant and some other grains), but the facility kept serving her food with gluten. Resident 1 stated when she eats gluten, it upsets her stomach.</p> <p>A review of Resident 1's admission Record, indicated she was admitted to the facility on [DATE], with diagnoses which included hypertension (HTN-high blood pressure), and she was allergic to gluten.</p> <p>A review of Resident 1's History and Physical, dated May 5, 2025, indicated the resident had the capacity to make decisions.</p> <p>A review of Resident 1's Order Summary Report, dated June 19, 2025, indicated .Fortified, NAS diet Regular texture, thin liquids consistency, gluten free diet . was ordered on May 20, 2025.</p> <p>On July 19, 2025, at 12:30 p.m., during observation, a Certified Nurse Assistant (CNA) served Resident 1's meal tray in the resident's room, and Resident 1's meal ticket indicated .Allergies .Gluten . The meal tray included ham with glaze, broccoli, potatoes and a serving of cornbread.</p> <p>On July 19, 2025, at 12:41 p.m., during a concurrent observation and interview with Resident 1 in her room, she was sitting in bed and looking at her meal. Resident 1 stated she could not eat the cornbread because it has gluten. Resident 1 stated she would only eat the vegetables.</p> <p>On July 22, 2025, at 9:44 a.m., during an interview with the Dietary Supervisor (DS), the DS stated she was familiar with Resident 1, and she was allergic to gluten. The DS stated there is a policy and spreadsheet they follow to be able to accommodate Resident 1's gluten allergy. The DS stated they do not have a specific recipe for cornbread. The DS stated they only use one kind of cornbread mix in the facility and they follow the recipe that is indicated on the label. The DS showed a five-pound cornbread mix, and the label indicated . Ingredients: Bleached Wheat Flour .Wheat Gluten . The DS stated she did not know why Resident 1 was served cornbread for lunch yesterday.</p> <p>On July 22, 2025, at 11:21 a.m., during an interview, the Director of Nursing stated the dietary staff should ensure that residents allergic to gluten are not getting any gluten.</p> <p>A review of the facility policy titled Gluten-Restricted Diet, dated 2023 indicated .Gluten is a general name given to the storage proteins present in wheat, rye, barley and oats. Intolerance to gluten can result in the inability of the small intestine to digest and absorb nutrients. It is important to review labels of all commercial, processed and pre-breaded food items .Avoid .cornbread . all products made from .wheat .</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy titled Food Allergies and Intolerances, dated August 2017 indicated .Residents with food allergies and/or intolerances are identified upon admission and offered food substitutions of similar appeal and nutritional value. Steps are taken to prevent resident exposure to allergen(s) .</p>		