

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  11/13/2025
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 0573  Level of Harm - Potential for minimal harm  Residents Affected - Some	Let each resident or the resident's legal representative access or purchase copies of all the resident's records.  (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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<p>F 0573</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide copies of medical records upon request and within two business days after receiving the request from an attorney on behalf of the resident, for one of two residents reviewed, Resident 1. This failure resulted in Resident 1's legal representative not receiving the requested records within the two working day timeframe. Findings: A review of Resident 1's medical record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included respiratory failure (a condition where the lungs are unable to get enough oxygen into the blood) and type 2 diabetes mellitus (high blood sugar). Further review of the medical record indicated Resident 1 was transferred out to the general acute care hospital on June 24, 2025, and did not return to the facility. On November 13, 2025, at 12:20 p.m., during an interview and record review of medical record requests, the Director of Medical Records (DMR) stated a resident, or their Power of Attorney (a person who have been legally authorized to act on another person's behalf in legal, financial, or medical matters) can request for medical records by completing an Authorization for Use or Disclosure of Protected Health Information form. The DMR stated it takes 24 hours to pull a resident's complete chart from PointClickCare (an electronic health record used by the facility). The DMR stated they have 30 days to fulfill a medical record request. The DMR stated when she receives a medical record request from a law firm or a subpoena, she forwards the request to their legal department. The DMR stated she keeps a folder of medical record requests she received from law firms. The DMR provided the folder, and it included a letter from Resident 1's attorney. A review of the letter sent by Resident 1's attorney dated October 1, 2025 indicated .Please be advised that this office represents (name of Resident 1) .we are requesting copies of (name of Resident 1) .records . Attached to the letter was an Authorization for Use or Disclosure of Protected Health Information that indicated the facility was authorized to release to (name of attorney) all health information pertaining to Resident 1's medical history, mental or physical condition and treatment received and it was signed by Resident 1's family member on August 30, 2025. The DMR stated she received the letter from Resident 1's attorney and sent it to the legal department on October 6, 2025, via email. The DMR stated the legal department retained an attorney for this request. The DMR stated she uploaded Resident 1's entire medical record to a secure link provided by the legal department on November 10, 2025, and had no further communication regarding the release of the records . The DMR stated it was up to the legal department to release Resident 1's medical records. The DMR stated it had been more than 30 days since the record request was received. On November 13, 2025, at 1:29 p.m., during an interview, the Director of Nursing (DON) stated the DMR handled medical record request and if it was for legal matters, the DMR sends it to their legal department. The DON state she does not know if their legal department should follow their policy. On November 13, 2025, at 2:20 p.m., during an interview, the DON stated the DMR does not have the responsibility to fulfill the medical record request of Resident 1's attorney because she already sent it to their legal department. The DON called their Nurse Consultant (NC) on speaker phone. The NC stated the facility's policy indicated they have 30 days to release the medical record if the request came from a law firm. The NC stated the DMR should release the medical record of Resident 1 and should only notify the legal department of the request. A review of the facility's policy and procedure Release of Information dated April 1, 2020, indicated .The resident may initiate a request to release such information contained in his/her records and charts to anyone he/she wishes. Such requests will be honored only upon the receipt of a written, signed and dated request from the resident or representative .non-personnel representative such as legal firms may have access to his/her records within 30 days of written request .</p>		