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	03/04/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the family member was notified, for one of three residents (Resident 1), when Resident 1 eloped (when a resident leaves the facility without the knowledge of the staff) from the facility.This failure had the potential to result in Resident 1's family member to not being aware of Resident 1's condition.Findings:A review of Resident 1's admission Record indicated he was admitted to the facility on [DATE], with diagnoses which included Wernicke's encephalopathy (a brain injury caused by lack of thiamine [vitamin]) and his family member was listed as emergency contact # 1.A review of Resident 1's Elopement and Wandering Risk Observation/Assessment dated February 14, 2026, indicated the resident is alert and oriented x 3 (name, place and time) and can follow instructions.A review of Resident 1's Nurse's Note dated February 15, 2026, at 11:00 p.m., created by Registered (RN) 1, indicated Resident 1 was alert, oriented x 2, follows command and ambulatory using a cane. Resident 1 came to the nurse station at 6:30 p.m., asked for a pen then sat in the lobby and did word search puzzles. At 8:50 p.m., RN 1 was notified that Resident 1 was not in his room and the staff searched for the resident in the facility. When he was not found a (code used by the facility for missing resident) was activated for resident search. Resident 1 was searched for outside the facility in proximity, but the resident was not around. The notes indicated the charge nurse (Licensed Vocational Nurse [LVN] 1) notified the family, called law enforcement and the medical doctor.A review of Resident 1's Social Service Note dated February 16, 2026, at 11:45 a.m., (nearly 15 hours after the staff first noticed Resident 1 was missing) indicated a late entry that the Social Service Director (SSD) was informed Resident 1 left the facility last night (February 15, 2026). The SSD attempted to contact Resident 1's family members but was initially unsuccessful. The SSD eventually spoke with Resident 1's family member, who stated Resident 1 was at (name of general acute care hospital).On March 3, 2026, at 1:10 p.m., during an interview with LVN 1 and a record review of Resident 1's medical record, LVN 1 stated she was familiar with Resident 1. LVN 1 stated Resident 1 was alert and oriented to name and place. LVN 1 stated Resident 1 was confused a few times. LVN 1 stated Resident 1 did not want to be in one place, he stayed in his room for a few hours then he would go to the activity room and to the patio. LVN 1 stated Resident 1 did not seem to be at risk of eloping.During the same interview, LVN 1 stated on February 15, 2026, she was the charge nurse for Resident 1, and she gave him his medications at 4:00 p.m., in the lobby, then Resident 1 ate his dinner between 4:30 to 5:00 p.m., in his room. LVN 1 stated when she made her rounds (routine checks) between 6:00 p.m. to 6:30 p.m., when she noticed Resident 1 was not in his room, and she notified RN 1, the CNA and announced their code for missing resident. LVN 1 stated she did not notify the family member because they were still looking for Resident 1. LVN 1 stated Resident 1's family member should have been notified.On March 4, 2026, at 9:26 a.m., during an interview, RN 1 stated she asked LVN 1 to call Resident 1's family member that he was not found. RN 1 stated family members should be notified as soon as the resident was not found.On March 4, 2026, at 1:59 p.m., during an interview, the Director of Nursing stated the RN or LVN are supposed to notify the resident's family member and document it in the medical record.A review of the facility's policy (continued on next page)

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
	555017	A. Building B. Wing	03/04/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and procedure titled, Emergency Procedure - Missing Resident dated August 2018 indicated, .Resident elopement resulting in missing resident is considered a facility emergency .Notify the family/responsible party and attending physician if the resident is not found in the facility or the grounds .Emergency Job Tasks .Nursing Staff .Notify the family/responsible person and inform him of his/her status .ensure the incident and events are documented objectively in the resident record including .notification of .family .

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	03/04/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe environment was provided for one of two residents, Resident 1, when Resident 1 exited the facility through the front door without the staff knowledge. Resident 1 was found wandering on the grounds of a college campus and was transported to a general acute care hospital (GACH) by emergency medical services.This failure had the potential to result in Resident 1 to sustain serious injury such as being struck by a vehicle or death.Findings:A review of Resident 1's admission Record indicated he was admitted to the facility on [DATE], with diagnoses which included Wernicke's encephalopathy (a brain injury caused by lack of thiamine [vitamin]).A review of Resident 1's Nursing Admission/re-admission Evaluation/Assessment dated, February 13, 2026, indicated the resident is alert and oriented to name and place, forgetful and follows direction at times.A review of Resident 1's Elopement and Wandering Risk Observation/Assessment dated February 14, 2026, indicated the resident is alert and oriented x 3 (name, place and time) and can follow instructions and expressed being unhappy or not accepting with placement at the facility.A review of Resident 1's Nurse's Note dated, February 15, 2026, at 11:00 p.m., created by Registered (RN) 1 indicated Resident 1 was alert, oriented x 2, follows command and ambulatory using a cane. Resident 1 was in his room at 3:15 p.m. Resident 1 came to the nurse station at 6:30 p.m., asked for a pen then sat in the lobby and did word search puzzles. At 8:50 p.m., RN 1 was notified that Resident 1 was not in his room and the staff searched for the resident in the facility and he was not found. A (code used by this facility for missing person) was activated for resident search. Resident 1 was searched for outside the facility in proximity, but resident was not around. A review of Resident 1's Nurses Note dated February 16, 2026, at 4:02 a.m., indicated a late entry that at approximately 3:52 a.m., an RN from (name of GACH) reported to the facility that Resident 1 was found by law enforcement on February 15, 2026, at 10:10 p.m., at (name of college campus) wandering (moving around with no purpose). On March 3, 2026, at 1:10 p.m., during an interview with Licensed Vocational Nurse (LVN) 1 and a review of Resident 1's medical record, LVN 1 stated she was familiar with Resident 1. LVN 1 stated Resident 1 was alert and oriented to name and place. LVN 1 stated Resident 1 was confused a few times. LVN 1 stated Resident 1 did not want to be in one place, he stayed in his room for a few hours then he would go to the activity room and to the patio. LVN 1 stated Resident 1 did not seem to be at risk of eloping (a resident leaving the facility without staff knowledge).During the same interview, LVN 1 stated on February 15, 2026, she was the charge nurse for Resident 1, and she gave his medications at 4:00 p.m. in the lobby, then Resident 1 ate his dinner between 4:30 to 5:00 p.m., in his room. LVN 1 stated when she made her rounds (routine checks) between 6:00 p.m. to 6:30 p.m., she noticed Resident 1 was not in his room, and she notified RN 1, the CNA, and announced their code for a missing resident. On March 4, 2026, at 9:26 a.m., during an interview, RN 1 stated she was familiar with Resident 1. RN 1 stated she was the RN supervisor on February 15, 2026, for the 3pm-11pm shift. RN 1 stated at 3:00 p.m., Resident 1 was in his room, at 5:40 p.m., Resident 1 was in the lobby with puzzles and books, and she approached him because it was dinner time. RN 1 stated Resident 1 was able to walk to his room, she helped him with his dinner tray, and she left the resident's room. A few minutes later, Resident 1 went back to the front nurses' station (Station 1), asked for a pen and sat down in the lobby. RN 1 stated between 10:00 to 11:00 p.m., she was notified that Resident 1 was not in his room and they searched everywhere for him.During the same interview, RN 1 stated there are six exit doors in the facility with alarms. RN 1 stated the front door has an alarm now and it didn't have an alarm before. RN 1 stated she cannot remember when the alarm was placed but it was due to something that happened recently.On March 4, 2026, at 10:52 a.m., during an interview, CNA 1 stated on February 15, 2026, he last saw Resident 1 at 5:50 p.m., when he picked up his dinner tray. CNA 1 stated he did not really (continued on next page)

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	03/04/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	check on Resident 1 because he was independent. CNA 1 stated he found out that Resident 1 was missing on February 16, 2026, when the Director of Staff Development called him.On March 4, 2026, at 11:14 a.m., during a concurrent interview and review of the facility's surveillance camera with the Maintenance Director (MTD) and Assistant Maintenance (AMT), the AMT stated Resident 1 left the facility through the front door. The surveillance camera showed Resident 1 dressed in regular clothes and exited the front door of the facility on February 15, 2026, at 6:59 p.m. The MTD stated the front door is locked at 8:00 p.m.On March 4, 2026, at 1:31 p.m., during an interview, LVN 2 stated no one is responsible for monitoring the front door after the receptionist leaves. LVN 2 stated there are nurses at Station 1 to keep an eye on the front door.On March 4, 2026, at 1:48 p.m., during an interview, RN 1 stated she stayed at Station 1 if there is nothing to do. RN 1 stated the LVNs monitor the front door after the receptionist leaves. RN 1 stated there is always an LVN at Station 1 or she would call a CNA to stay there to make sure no resident goes out. RN 1 stated there should always be someone at Station 1 but sometimes they get busy, especially the hours between 6:00 to 9:00 p.m. RN 1 stated it was not a guarantee there is always someone sitting at Station 1.On March 4, 2026, at 1:59 p.m., during an interview, the Director of Nursing (DON) stated the desk nurse, charge nurse and the RN keeps an eye on the front door after the receptionist leaves. The DON stated there is always somebody watching the front door. The DON stated a resident leaving through the front door can happen if the nurses bent down or are on the phone. A review of the facility's policy and procedure titled, Safety and Supervision of Residents dated July 2017, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .