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	10/24/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48000 Based on observation, interview, and record review, the facility failed to accommodate the needs for one of 27 sampled residents (Resident 126), when the call light button was observed not within reach. This failure had the potential for Resident 126 not to be able to call staff for assistance which could result in needs of the resident not being met as well as the delay in the provision of care. Findings: On October 21, 2024, at 10:24 a.m., during an observation and concurrent interview with Resident 126, the resident's call light button was observed on the floor behind the resident's bed. Resident 126 stated he was not sure where the call light was and he could not reach his call light for assistance. Resident 126's record was reviewed. Resident 126 was admitted to the facility on [DATE], with diagnoses that included urinary tract infection, obstructive uropathy (condition in which the flow of urine is blocked) and diverticulosis (a condition in which you have small pouches in your colon). A review of Resident 126's Minimum Data Set (MDS - a standardized comprehensive assessment and care planning tool) dated October 3, 2024, indicated Resident 126's BIMS (brief interview for mental status, ranges from 0 to 15) score was 12, which indicated moderate cognitive impairment. A review of Resident 126's History and Physical dated September 30, 2024, indicated Resident 126 had the capacity to make his own decisions. On October 21, 2024, at 10:32 a.m., an observation and concurrent interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 agreed the Resident 126 was not able to reach the call light, and stated the call light should be within the resident's reach. CNA 1 stated that the call light should not be on the floor behind the bed. CNA 1 further stated Resident 126 could fall, have an emergency, or not be able to get assistance if he needed it. On October 21, 2024, at 10:41 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 acknowledged that call light should not be on the floor and should be within reach of the resident. LVN 1 stated if Resident 126's call light was not within reach, it increases his risk of fall and would cause a delay in the resident receiving assistance. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 24, 2024, at 7:59 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated that it is the practice of the facility to keep the resident's call light within reach. The DON further stated not having the resident's call light within reach could delay his care and the resident could have a medical emergency, fall, or need assistance. A review of the facility's policy and procedure titled Answering the Call Light, revised October 2010 indicated . The purpose .is to respond to the resident's request and needs .be sure that the call light is within easy reach of the resident .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed for three of eight residents reviewed (Resident 183, 101, and 32) to ensure: 1. For Resident 183, the central dialysis catheter was identified, assessed and monitored; This failure had the potential to delay the necessary care and services Resident 183 may need if complications developed with the central dialysis catheter; 2. For Resident 101, the physician order for fluid restriction was followed; This failure had the potential to result in fluid overload and a decline in Resident 101's health condition; and 3. For Resident 32, a skin condition was identified, assessed, monitored, and necessary treatment was implemented. This failure had the potential to result in Resident 32's development of skin breakdown and other skin complications. Findings: 1. On October 21, 2024, at 11:38 a.m. Resident 183 was observed lying in bed with his eyes closed not responsive to verbal call. Resident 183 was on oxygen at two liters per minute through nasal cannula (a plastic tubing with two prongs that delivers oxygen through the nose). A Ziploc bag labeled Dialysis Kit was taped on the wall above the resident's bed. . On October 21, 2024, at 4:05 p.m., Resident 183 was out for hemodialysis treatment (a process that uses a machine to filter out waste and fluid from the body when the kidneys are no longer functiong adequately). During a concurrent observation and interview on October 22, 2024, at 4:45 p.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 183's hemodialysis access catheter was on his left upper chest. The catheter was observed wrapped with white gauze (a soft dressing). LVN 2 stated Resident 183 goes to his dialysis treatment on Mondays, Wednesdays, and Fridays. During a review of Resident 183's record on October 23, 2024, the record indicated prior to admission to the skilled nursing facility, Resident 183 was admitted to the acute hospital on September 13, 2024, for emergent acute dialysis due to lack of an available dialysis center. The hospital chest X-ray dated September 13, 2024, indicated Resident 183 had a left chest tunneled catheter (a type of dialysis catheter that allows for high blood flows during dialysis) in position. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 183 was admitted to the skilled nursing facility on September 28, 2024, with diagnoses which included End Stage Renal Disease (ESRD - a kidney disease), and on hemodialysis. The nursing admission assessment dated [DATE], indicated Resident 183 had a Left AV shunt (a surgically created connection between vein and artery to allow access to the bloodstream for dialysis). Physician orders for the months of September 2024 and October 2024, indicated .Resident has AV Fistula located on LUA (left upper arm). Monitor for the presence of bruit (a whoosing sound heard by using a stetoscope .and thrill (a vibration felt by placing your fingers over the shunt) .Monitor Q Shift for bleeding, drainage .swelling .start date 9/30/24 . There was no documented evidence the left upper chest central dialysis catheter was identified, assessed, and monitored when Resident 183 was admitted to the facility on [DATE]. There was no documented evidence a care plan for Resident 183's central dialysis catheter and access site on the left upper chest was initiated upon admission. The document titled, HEMODIALYSIS COMMUNICATION RECORD, completed by the licensed nurse prior to the scheduled dialysis and completed by the dialysis center licensed nurse indicated that on September 30, 2024, October 11, 14, 16, 18, 2024, the access site of Resident 183's dialysis was located on his left upper chest. The receiving and accepting licensed nursing staff at the facility indicated Resident 183 had an AV Shunt with bruit and thrill. There was no assessment of the left upper chest central dialysis catheter since September 30, 2024, pre (before) and post (after) dialysis on Mondays, Wednesdays and Fridays. The nurse's notes from September 28, 2024 to October 21, 2024, did not identify the central dialysis catheter on Resident 183's left upper chest. There was no documented evidence Resident 183's central dialysis catheter on the left chest was assessed and monitored on every nursing shift. During a concurrent observation and interview on October 23, at 3:35 p.m., with the Assistant of Director Of Nursing (ADON) in Resident 183's room, the ADON stated Resident 183's hemodialysis access catheter was on the left upper chest. On October 23,2024, at 3:47 p.m., a concurrent interview and record review was conducted with the ADON. The ADON stated Resident 183's left upper chest dialysis access was not identified and assessed on admission. She stated there was no monitoring of the left upper chest dialysis catheter. She stated the licensed staff should have identified the left upper chest dialysis upon admission and monitored the central dialysis catheter and the dialysis access site on every shift. On October 24, 2024, at 9:40 a.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated Resident 183 was being dialyzed using the upper chest dialysis catheter. He stated he would also check Resident 183's left upper arm AV Fistula. He stated the central dialysis catheter on resident's left upper chest was not monitored on the MAR (Medication Administration Record). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 24, 2024, at 10:30 a.m., a concurrent interview with the ADON and record review of the document titled Hemodialysis Communication Record was conducted. The ADON stated the licensed staff were monitoring the left upper arm AV shunt. The ADON verified that the left AV shunt had no thrill or bruit, and stated that was the previous site of Resident 183's hemodialysis access, which was being monitored. A review of the facility's policy and procedure titled, Admission Assessment, dated September 2012, indicated, .The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychological condition upon admission for the purpose of managing the resident, initiating the care plan . A review of the facility's policy and procedure titled, End-Stage Renal Disease, Care of a Resident with, dated September 2010, indicated, .Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care .Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents . Education and training of staff includes .the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis . 50309 2. On October 22, 2024, at 9:29 am Resident 101 was interviewed. Resident 101 was alert and oriented. Resident 101 stated he was on dialysis. Resident 101 stated staff did not follow the fluid restriction ordered by his physician and gave him more fluids than he was allowed per day. On October 22, 2024, Resident 101's record was reviewed. Resident 101 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (CHF - fluid build-up in the body because the heart cannot pump well enough), chronic kidney disease (kidneys are damaged and excess fluid and waste remain in the body), and dependence on renal (kidney) dialysis. The physician's order dated August 27, 2024, indicated, .1500ml (milliliters - a unit of measurement) fluid restrictions. 960 ml from the dietary .540ml from nursing . The care plan, initiated August 28, 2024, indicated, .At risk for .edema (swelling caused by fluid retention) . weight fluctuations secondary to ESRD (End-Stage Renal Disease) with dependence on dialysis, chronic kidney failure .Fluids as ordered. Restrict or give as ordered .Fluid Restriction 1500 ml .960ml from the Dietary .540ml from nursing . The fluid intake record (a record indicating the total amount of fluid per day) for the month of September 2024, indicated Resident 101 had 2100 ml on September 29, 2024. The fluid intake record for the month of October 2024, indicated Resident 101 had 1600 ml on October 2, 2024, 1900 ml on October 10, 2024, 3100 ml on October 14, 2024, 2700 ml on October 15, 2024, 1715 ml on October 16, 2024, 2071 ml for October 17, 2024, 2020 ml on October 20, 2024, exceeding the physician's order of 1500 ml per day. On October 23, 2024, at 3:11 pm, a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 4. LVN 4 stated the physician's order for fluid restrictions was not followed. LVN 4 stated the fluid restrictions should have been followed, as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 23, 2024, at 3:53 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON confirmed the physician's order for fluid restrictions was not followed. The DON stated the fluid restrictions should have been followed, as ordered by the physician. The facility policy and procedure titled, Encouraging and Restricting Fluids, revised October 2010, was reviewed. The policy indicated, .The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids .Verify that there is a physician's order for this procedure .Follow specific instructions concerning fluid intake or restrictions . 3. On October 21, 2024, at 3:39 p.m., during a concurrent observation and interview with Resident 32, Resident 32 was observed sitting on his bed, alert and oriented. The resident was observed to have discoloration on both lower legs and his skin was scaly and dry. The resident stated his legs have been very dry and itchy, and further stated, no one has checked them. On October 22, 2024, at 11:03 a.m., a concurrent observation and interview was conducted with Certified Nurse Assistant (CNA) 2. CNA 2 stated Resident 32 was able to take showers by himself and she had not checked his legs. CNA 2 stated they use a shower sheet that each CNA fills out every shift to report abnormal findings to the licensed nurses. On October 22, 2024, at 11:18 a.m., a concurrent observation and interview was conducted with the Treatment Nurse (TN). The TN observed Resident 32's lower legs and stated his skin was very dry. The TN stated she was not aware of Resident 32's leg skin condition and no one had reported it to her. The TN stated Resident 32's legs should have been assessed and the resident offered lotion or ointment. The TN further stated the dry skin can cause Resident 32 to have skin breakdown and lead to infection. On October 23, 2024, at 2:33 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated CNAs are expected to report abnormal findings to the licensed nurses so that they can make an assessment on the resident. The DSD stated Resident 32's legs should have been assessed and monitored to avoid skin breakdown. On October 23, 2024, at 2:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated CNAs should report changes in resident's condition, including their skin. The DON stated Resident 32's legs should have been assessed and the dryness should have been treated to prevent skin breakdown and other complications. A review of Resident 32's record indicated the resident was admitted to the facility on [DATE], with diagnoses that included Atrial-fibrillation (abnormal heartbeat), tachycardia (heart rate beats faster than normal), CHF, and abnormal gait (how a person walks) and mobility. A review of Resident 32's care plan, initiated on April 28, 2024, indicated .Risk for Skin Breakdown .Check skin during daily care provisions .notify physician of abnormal findings . A review of Resident 32's care plan, initiated on April 28, 2024, indicated .Resident is on anticoagulant (blood thinner) therapy for deep vein thrombosis (DVT - blood clots) .Daily skin inspection .Report abnormalities to the nurse . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy and procedure titled, Body Skin Evaluation, dated January 2023, indicated .It is the policy of this facility to monitor the resident's skin condition daily and provide documented licensed nurse evaluations on an as needed .Nursing assistant will check resident's skin on schedules shower days and shall report any skin integrity impairment to the licensed nurse for follow up .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to ensure infection prevention and control program practices were implemented for two of seven residents reviewed (Residents 48 and 39) when: 1. For Resident 48, the oxygen nasal cannula (a plastic tube with two prongs that deliver oxygen through the nose) was left exposed on top of the resident's bed; and 2. For Resident 39, the wound vacuum, also known as vacuum-assisted closure (VAC - a machine that uses suction to help the wound heal more quickly) was left at the bedside table. These failures had the potential to increase the spread and the development of infection and would have placed Resident 39 and 48 at risk for illnesses and other complications. Findings: 1. On October 21, 2024, at 1:19 p.m., Resident 48 was not in her room. Resident 48's oxygen nasal cannula tubing was observed lying on top of her bed. The oxygen was on at three liters (a unit of measurement) per minute. On October 21, 2024, at 2 p.m., Resident 48's oxygen nasal cannula tubing remained on top of the resident's bed. On October 21, 2024, at 2:15 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated the resident's oxygen nasal cannula tubing should not be on the top of resident's bed. He stated the oxygen tubing should be kept inside the plastic bag when not in use to prevent contamination and risk for infection. On October 21, 2024, at 3:46 p.m., a concurrent observation and interview was conducted with Resident 48. Resident 48 was observed sitting at the side of her bed with oxygen on at three liters per minute through nasal cannula. She stated she left her oxygen tubing on top of her bed when she left her room. On October 23, 2024, Resident 48's record was reviewed. Resident 48 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - a lung disease). The physician orders for the month of October 2024, included .Oxygen at 2-5 LPM (liters per minute) via nasal cannula PRN (as needed) . During an interview on October 24, 2024, at 2:35 p.m., with the Director Of Nursing (DON), the DON stated the oxygen nasal cannula tubing should be kept in the plastic bag when not in use to prevent the risk for infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Prevention of Infection Respiratory Equipment, dated November 2011, indicated, .The purpose of this procedure is to guide prevention of infection associated with respiratory therapy task and equipment among residents and staff .Store the circuit in plastic bag, marked with date and resident's name . 50309 2. On October 23, 2024, at 3:15 p.m., Resident 39 was observed in her room awake and lying on the bed. There was a wound vacuum device and tubing with brown colored sediment observed on Resident 39's bedside table. On October 23, 2024, at 3:50 p.m., during a concurrent observation and interview with the Treatment Nurse (TN), the TN verified the device and tubing were on Resident 39's bedside table. The TN stated she provided a wound dressing change to Resident 39 and did not discard the used wound VAC tubing after the procedure. The TN stated, I forgot to throw the tubing away. She stated she should have thrown it right away and disinfected the wound VAC machine to prevent the spread of germs or infections to the residents. On October 24, 2024, at 10:31 a.m., the Infection Preventionist (IP) was interviewed. The IP stated, the TN should have discarded the used tubing right away after providing treatment and should have disinfected the wound vacuum. The IP further stated if the TN did not discard the supplies used after wound treatment, germs can spread through cross contamination on the bed side table and potentially spread infection to the residents. On October 24, 2024, at 11:13 a.m., the Director of Nursing (DON) was interviewed. The DON stated the TN should have checked the surroundings before and after providing treatment and discarded the used supplies. She further stated any break in infection control can result in cross contamination and germs can spread to the residents. On October 24, 2024, Resident 39's record was reviewed. Resident 39 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer (skin injury) sacral region (tail bone) and history of urinary tract infections. A review of Resident 39's physician order dated April 19, 2024, indicated, .Cleanse coccyx (tail bone) with wound cleanser, apply black foam and attach to wound vac .set at 125mmhg (unit of measurement) continuous pressure every day shift .Enhanced barrier precautions related to chronic wound every shift . A review of facility policy and procedure titled, Wound Care, dated October 2010, indicated, .Discard disposable items in the designated container .Wipe reusable supplies with alcohol as indicated . A review of facility policy and procedure titled, Infection Prevention and Control Program, dated October 2018, indicated, .Prevention of Infection .educating staff and ensuring that they adhere to proper techniques and procedures .