

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2025
NAME OF PROVIDER OR SUPPLIER  Riverside Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE  8781 Lakeview Avenue Riverside, CA 92509	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure one of two residents, Resident 2, was provided timely access to her personal funds.</p> <p>This failure resulted in Resident 2 being upset and had the potential to result in anxiety (feeling of uneasiness) or a feeling of loss of control impacting her overall well-being.</p> <p>Findings:</p> <p>On February 14, 2025, at 9:14 a.m., during an interview, Resident 2 stated she had a trust account (fund that holds a resident's money for their use in the nursing home) with the facility. Resident 2 stated she requested funds from her account through the Business Office Manager Assistant (BOMA) on February 13, 2025, but was given the runaround. Resident 2 stated she had still not received the money she requested.</p> <p>A review of Resident 2's medical record indicated she was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause ongoing breathing difficulties).</p> <p>A review of Resident 2's Minimum Data Assessment (an assessment tool) dated January 30, 2025, indicated she had no cognitive impairment.</p> <p>On February 19, 2025, at 4:02 p.m., during an interview, the BOMA stated Resident 2 requested for money, last week, either on Wednesday (February 12, 2025) or Thursday (February 13, 2025). The BOMA stated the facility had no available funds and that the corporate office was taking forever to sign the check because the person responsible for signing was sick. She stated when she explained that to Resident 2, she got upset. The BOMA stated the facility was supposed to have funds available to residents all the time, but she had no control over it.</p> <p>On February 20, 2025, at 9:50 a.m., during a concurrent observation and interview, Resident 2 was in her room, lying in bed, alert and conversant. Resident 2 stated the amount of money she requested depends on the balance of her account. If she had a balance of four hundred dollars, she would request for two hundred dollars.</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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On February 20, 2025, at 1:18 p.m., during a follow up interview, the BOMA stated Resident 2 requested two hundred dollars last week and always requested the same amount. The BOMA stated when the residents requested for money, they ususally received the money within five minutes.</p> <p>On February 20, 2025, at 3:00 p.m., during an interview, the Administrator (ADM) stated when residents request for their money, it should be given to the residents in a timely manner. The ADM stated the facility was holding funds for the residents so the funds should be available to them. The ADM stated she was not aware that the facility had no funds available, and Resident 2 never spoke to her about the money she requested.</p> <p>On February 28, 2025, at 4:43 p.m., during a telephone interview, the ADM stated the facility should provide the residents with their requested money on the same business day. The ADM stated the BOMA should have informed her immediately when she knew that the facility had no available funds so that she could have taken action to secure funds as soon as possible.</p> <p>A review of the facility's policy and procedure titled, Resident Trust Account dated February 2017, indicated . Provide the resident or resident representative with access to trust account funds as requested and if funds are available to the resident or resident representative .</p>		

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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>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure treatments ordered by the physician were administered for two of two residents, Residents 2 and 5.</p> <p>This failure had the potential to result in worsening of Residents 2 and 5 ' s skin conditions.</p> <p>Findings:</p> <p>On February 14, 19, and 20, 2025, unannounced visits were conducted at the facility.</p> <p>1. On February 14, 2025, at 12:35 p.m., during a concurrent observation and interview, Resident 2 was in her room, lying in bed, alert and conversant. Resident 2 stated she had tinea corporis (a fungal infection of the skin that causes circular, itchy, and scaly rashes) on her right breast and right leg, but she did not receive treatment for five days.</p> <p>A review of Resident 2's medical record indicated she was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause ongoing breathing difficulties).</p> <p>A review of Resident 2's Minimum Data Assessment (MDS-an assessment tool) dated January 30, 2025, indicated she had no cognitive impairment.</p> <p>A review of Resident 2's Treatment Administration Record (TAR) for the month of February 2025 indicated multiple blanks as follows:</p> <p>a.Ketoconazole External Cream 2 % (Ketoconazole Day (Topical Apply to back topically every day shift for tinea corporis for 4 Weeks . with a start date of January 27, 2025, was blank on February 4 and 10, 2025;</p> <p>b.Ketoconazole External Cream 2 % (Ketoconazole (Topical) Apply to Buttocks topically every day shift for tinea corporis for 4 Weeks, with a start date of January 29, 2025, was blank on February 4 and 10, 2025;</p> <p>c.Derma-Smothe/FS Body External Oil 0.01 % (Fluocinolone Acetonide) Apply to back topically every day shift for tinea corporis until 02/10/2025 23:59 (11:59 p.m.) Cleanse site with N.S (normal saline) pat dry apply body oil and leave to air open . with a start date of February 3, 2025, was blank on February 4 and 10, 2025;</p> <p>d.Derma-Smothe/FS Body External Oil 0.01 % (Fluocinolone Acetonide) Apply to Buttocks topically every day shift for tinea corporis until 02/10/2025 23:59 Cleanse site with N.S pat dry apply body oil and leave to air open . with a start date of February 3, 2025 were blank on February 4 and 10, 2025;</p> <p>(continued on next page)</p>		

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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>e. Triple Antibiotic External Ointment (Neomycin Bacitracin-Polymyxin) Apply to right upper leg topically in the morning for Skin tear for 7 Days cleanse site with normal saline, apply TAO (triple antibiotic ointment) and dry dressing . with a start date of February 9, 2025, was blank on February 10, 2025;</p> <p>f. Derma-Smothe/FS Body External Oil 0.01 % (Fluocinolone Acetonide) Apply to affected area topically every day shift for Tinea for 21 Days . with a start date of February 15, 2025, were blank on February 15 and 16, 2025; and</p> <p>g. Right upper leg skin tear: cleanse (sic) with normal saline, pat dry, apply calmoseptine (sic) ointment, cover with dry dressing x 14 days every day shift for 14 Days with a start date of February 16, 2025 was blank on February 16, 2025.</p> <p>On February 19, 2025, at 10:20 a.m., during an interview, Certified Nurse Assistant (CNA) 1 stated Resident 2 did not receive treatments on Friday, Saturday, and Sunday. CNA 1 further stated the facility did not have a Treatment Nurse (TN) last Saturday and Sunday (February 15 and 16, 2025) and treatment was not provided to the residents.</p> <p>On February 19, 2025, at 1:07 p.m., during a concurrent interview and record review of Resident 2's TAR of the month of February 2025, Licensed Vocational Nurse (LVN) 3 stated she was the TN. LVN 3 stated there were multiple blanks on Resident 2 's TAR. She stated on February 4, 2025, she was the TN but was re-assigned to be the charge nurse because another LVN had to leave due to a family emergency. She stated she was not the TN on February 10, 14, and 15. She stated she was the TN on February 16, 2025, but was re-assigned again to be the charge nurse because another LVN called off. She stated when there was no TN, the charge nurses for each cart were responsible for providing treatment to the residents. She stated it was very hard to be a charge nurse to pass medications and provide treatments. She stated there were call offs on the days she worked, that's why treatments were not provided. She stated when Resident 2 did not receive her treatment, her itchiness would increase, and the skin tear could get larger or infected. LVN 3 further stated treatments should be administered as ordered by the physician.</p> <p>2. On February 20, 2025, at 10:00 a.m., during a concurrent observation and interview, Resident 5 was in her room, awake, and lying in bed. Resident 5 stated she had a wound and received treatment today. Resident 5's responses to the rest of the interview were unclear.</p> <p>On February 20, 2025, at 10:08 a.m., during an interview, Certified Nurse Assistant (CNA) 2 stated Resident 5 had a wound on her left leg that was bandaged up.</p> <p>A review of Resident 5's medical record indicated she was admitted to the facility on [DATE], with diagnoses which included stroke with left sided weakness.</p> <p>A record review of Resident 5's Minimum Data Set (MDS- an assessment tool) dated February 13, 2025, indicated she had cognitive impairment.</p> <p>A record review of Resident 5's Treatment Administration Report (TAR) for the month of February 2025, indicated the following:</p> <p>(continued on next page)</p>		

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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>a. Betadine External Solution 10 % (Povidone-Iodine) Apply to Left heel topically every day shift every other day for DTI (deep tissue injury-purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) gently cleanse area with normal saline, pat dry, apply betadine to affected area, cover with ABD (abdominal) pad, wrap with kerlix, and secure with tape until resolved . with a start date of January 4, 2025, was blank on February 11, 2025; and</p> <p>b. Nystatin-Triamcinolone External Ointment 100000-0.1 UNIT/GM-% (Nystatin-Triamcinolone) Apply to inner thigh topically every day and evening shift for fungal infection for 30 Days Cleanse site with N.S (normal saline) pat dry apply cream and leave to air dry . with a start date of January 19, 2025, were blank in the morning shift of February 11 and 16, 2025, and in the evening shift for February 11 and 12, 2025.</p> <p>On February 20, 2025, at 10:20 a.m., during an interview with LVN 4, she stated she worked on February 10 and 11, 2025, as charge nurse and did not recall being told to provide treatment to the residents.</p> <p>On February 20, 2025, at 11:22 a.m., during an interview, LVN 5 stated there was always a treatment nurse at the facility. On February 10 and 14, 2025, the treatment nurse may have left early but she was not sure. LVN 5 stated Resident 2 was very particular with staff, and she only preferred a specific treatment nurse. She stated she was not sure if she provided treatment to any residents on February 10 and 14, 2025.</p> <p>On February 20, 2025, at 11:30 a.m., during an interview, LVN 6 stated she worked on February 15, 2025, and she stated she was never told to do the treatments. She stated she does not recall providing treatment to Resident 5.</p> <p>On February 20, 2025, at 12:05 p.m., during a follow up interview and record of Resident 5's TAR for the month of February 2025, LVN 3 stated there were multiple blanks on Resident 5's TAR. She stated if there were multiple blanks on the TAR it means the treatment was not done.</p> <p>On February 20, 2025, at 12:30 p.m., during an interview, LVN 8 stated the charge nurses were responsible for providing treatment when the facility did not have a treatment nurse. LVN 8 stated it was difficult to pass medications and provide treatment to all residents for one charge nurse.</p> <p>On February 20, 2025, at 1:45 p.m., during an interview, the Director of Nursing (DON) stated she expected the treatments to be provided as ordered by the physician. The DON stated the facility is struggling with treatment nurses, but they have on call nurses they reach out to provide treatments. The DON stated there was no proof that the treatments were administered to Resident 2 and 5. The DON stated the charge nurse should do their own treatments when there ' s no treatment nurse. The DON stated when treatments are administered, it should be documented in the TAR. The DON stated when treatments were not administered to Residents 2 and 5, their skin condition could worsen.</p> <p>On February 28, 2025, at 3:25 p.m., during a telephone interview, the DON stated the facility did not have a policy indicating treatments should be provided as ordered by the physician.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48240</b></p> <p>Based on interview and record review, the facility failed to ensure the call light was functioning for one of three residents, Resident 1.</p> <p>This failure had the potential to result in Resident 1 not being able to call for help.</p> <p>Findings:</p> <p>On February 14, 19, and 20, 2025, unannounced visits were conducted at the facility.</p> <p>On February 14, 2024, at 12:20 p.m., during an observation inside room [ROOM NUMBER], bed A, the call light was plugged into the wall but did not activate when it was pressed.</p> <p>On February 19, 2025, at 5:48 p.m., during a concurrent observation and interview with Resident 1 in his room, Resident 1 was sitting in bed, and eating dinner. His call light was plugged into the wall, wrapped on the bed rail by his left-hand side. Resident 1 stated it was okay to turn on the call light. The call light did not activate. Resident 1 stated nobody would know if he was dying if the call light was not functioning.</p> <p>On February 19, 2025, at 5:51 p.m., during a concurrent observation of Resident 1 and interview with Licensed Vocational Nurse (LVN) 1, LVN 1 was asked to check Resident 1's call light. LVN 1 stated it wasn't working. LVN 1 stated Resident 1's call light was supposed to be working. LVN 1 stated the charge nurse assigned to Resident 1 was responsible for making sure the call light was functioning. LVN 1 stated Resident 1 was at risk for not being able to get assistance when his call light was not working.</p> <p>A review of Resident 1's medical record indicated he was admitted to the facility on [DATE], with diagnoses which included end stage renal disease.</p> <p>A review of Resident 1's Minimum Data Set (an assessment tool) dated December 12, 2024, indicated he had moderate cognitive impairment (needs assistance with daily tasks) and he requires partial/ moderate (a level of help where a helper does less than half of the work needed to complete an activity) to substantial/ maximal (a level of assistance where a helper does more than half of the work ) assistance with most activities of daily living).</p> <p>A review of Resident 1's care plan titled, The resident is at risk for falls r/t (related to): confusion . initiated on December 17, 2024, included interventions such as .Be sure The (sic) resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance .</p> <p>On February 20, 2025, at 1:45 p.m., during an interview, the Director of Nursing (DON) stated all direct care staff, and the department heads are responsible for ensuring call lights are functioning. The DON stated Resident 1 wouldn't be able to call for help if his call light was not functioning. The DON stated Resident 1's call light should have been functioning.</p> <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility ' s policy and procedure titled, Call Light Outage Plan dated July 2022 indicated . Report all defective lights .promptly .Staff will notify maintenance of malfunctioning call lights .</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48240</p> <p>Based on observation, interview, and record review, the facility failed to ensure the room was safe for two of two residents, Residents 3 and 4, when the floor tile was broken inside their room.</p> <p>This failure had the potential for Residents 3 and 4 to have a fall.</p> <p>Findings:</p> <p>On February 14, 19, and 20, 2025, unannounced visits were conducted at the facility.</p> <p>On February 14, 2025, at 10:44 a.m., during an observation in room [ROOM NUMBER], there was a broken floor tile by the restroom door. The damaged portion of the tile measured approximately three inches long and two inches wide, with black debris present in and around the area.</p> <p>A review of Resident 3's medical record indicated he was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause airflow obstruction and breathing difficulties).</p> <p>A review of Resident 3's Mimimum Data Set (MDS - an assessment tool) dated January 15, 2025, indicated he did not have cognitive impairment.</p> <p>On February 14, 2025, at 10:46 a.m., during a concurrent observation and interview, Resident 3 was in his room, sitting in his wheelchair, alert and conversant. Resident 3 stated the broken floor by the restroom floor had been broken for a while, but he was not sure how long.</p> <p>On February 20, 2025, at 10:30 a.m., during a concurrent observation of room [ROOM NUMBER] and an interview with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the floor by the restroom was broken and he did not notice it until now. LVN 2 stated Resident 4, who was blind, used the restroom more than the other residents in the room.</p> <p>A review of Resident 4's medical record indicated he was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (high blood sugar level) and legal blindness.</p> <p>A review of Resident 4's MDS dated [DATE], indicated he had no cognitive impairment.</p> <p>On February 20, 2025, at 10:30 a.m., during a concurrent observation of room [ROOM NUMBER] and an interview with the Maintenance Director (MTD), the MTD stated there was a broken floor tile by the restroom. The MTD stated he knew about this yesterday (February 19, 2025) and he went to the store to buy wood filler but was told that polymer clay (synthetic moldable material that can be used to fill small cracks, chips or imperfection on floor tiles) was better. The MTD stated he submitted a list of items he needed to fix the flooring in room [ROOM NUMBER] to corporate to be approved.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On February 20, 2025, at 3:00 p.m., during an interview, the ADM stated she found out about the broken floor in room [ROOM NUMBER] on February 19, 2025, and she did not receive any prior reports that it was broken.</p> <p>On February 28, 2025, at 4:43 p.m., during a telephone interview, the ADM stated there are multiple staff that enters the residents' rooms. The ADM stated it was the responsibility of all staff to alert the MTD if there are any broken floor tiles. The ADM stated the broken floor in room [ROOM NUMBER] was a tripping hazard, and Residents 3 and 4 could trip and fall. have tripped.</p> <p>A review of the facility's policy and procedure titled, Maintaining Resident Rooms dated April 2017, indicated . Resident rooms are inspected and maintained on a periodic basis to ensure proper function .Check for stained, broken, or chipped floor tile or sheet vinyl .Repair or replace faulty equipment and furnishings .</p>