STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555330	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Postacute Care	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an allegation of physical abuse involving one of three sampled resident (Resident 1) and a facility staff was reported to California Department of Public Health (CDPH - State Agency-Licensing and Certification Program) immediately or not later than two hours. The facility was made aware of the alleged physical abuse on March 5, 2025. This failure has the potential for delayed investigation which placed Resident 1 at risk for further abuse while at the facility. Findings: A review of Resident 1's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia (a group of symptoms affecting memory, thinking and social abilities). A review of Resident's Minimum Data Set (an assessment tool), dated December 12, 2024, indicated he had moderate cognitive impairment. A review of Resident 1's Nurses' Notes indicated the following: a. March 5, 2025, at 5:49 p.m., Resident states she kept punching me and punching me .Administrator notified . b. March 5, 2025, at 6:30 p.m., Administrator notified me (RN 1) that a Licensed Vocational Nurse alerted her of resident reporting abuse by a CNA (name of CNA) . Further review of Resident 1's Nurses' Notes, dated March 5, 2025, indicated there was no documented evidence CDPH was notified of Resident 1's allegation of abuse. (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 21, 2025, at 11:07 a.m., during an interview, Certified Nurse Assistant (CNA) 1 stated she was the CNA for Resident 1 on March 5, 2025, for the 3-11 (evening) shift and she changed him because he had a bowel movement. CNA 1 stated an hour after she provided care for him (Resident 1), the LVN informed her that Resident 1 had reported that someone punched him. On April 21, 2025, at 3:21 p.m., during an interview with Registered Nurse (RN) 1, RN 1 stated any allegations of abuse should be reported to law enforcement, Ombudsman and CDPH within two hours from when it happened. RN 1 stated LVN 1 notified the Administrator (ADM) of Resident 1's allegation involving CNA 1. RN 1 stated she could not recall why she did not fax the report on the alleged abuse involving the resident (Resident 1) to CDPH. RN 1 further stated she did not call CDPH either. On April 21, 2025, at 4:15 p.m., during an interview, the ADM stated CDPH should have been notified of the allegation of abuse on March 5, 2025, no later than 7:40 p.m. A review of the facility's policy and procedure titled Abuse and Neglect Prohibition Policy dated June 2022 indicated .When an abuse is identified, the appropriate steps to protect residents from additional abuse will be implemented immediately, which will include .Reporting the alleged violation and investigation within required timeframes .Reporting of incidents .Upon receiving information concerning a report of .alleged abuse .the Administrator or designee will perform the following .All alleged violations - Immediately but not later than .2 (two) hours - if the alleged violation involves abuse .The Licensing and Certification Program District Office is required to receive these reports .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to, for one of three sampled residents (Resident 3): 1. Re-assess the blister on the right elbow of Resident 3, initially observed during re-admission to the facility on April 13, 2025, and 2. Administer treatment to Resident 3's right elbow blister, when it was observed on April 13, 2025. These failures resulted in the worsening of the right elbow blister to a Stage 4 pressure injury (bed sore-full thickness skin loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer). Findings: On April 23, 2025, at 9:34 a.m., during interview with Resident 3 in her room, Resident 3 stated she had wounds on her right elbow and left heel, and she acquired those in the facility. A review of Resident 3's admission Record medical record indicated the resident was re-admitted to the facility on [DATE], with diagnoses which included rheumatoid arthritis. A review of the General Acute Care Hospital (GACH) Notes indicated the following: - Wound Nurse Record, dated April 10, 2025, the resident has history of chronic wounds, and had pressure injuries on the right buttock, left buttock, coccyxx, right first toe, left heel, and purple bruising on BUE (bilateral upper extremity) with no open skin. -PA(Physician Assistant)/NP (Nurse Practitioner) Progress notes, dated April 13, 2025, discharged . Further review did not indicate open area in the right elbow. A review of Resident 3's Nursing admission Assessment, dated April 14, 2025, indicated Resident 3 did not have any pressure injury on her right elbow. Further review of the admission assessment included Braden Skin Risk Scale & Skin Assessment which indicated the following: a. Sensory Perception: Ability to respond meaningfuly to pressure-related discomfort- 4. No impairment (responds to verbal commands). b. Moisture: Degree to which skin is exposed to moisture. - 1. Constantly Moist (skin is kept moist almost constantly by perspiration, urine). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	c. Activity: Degree of physical activity- 2. Chairfast (ability to walk is severely limited or nonexistent). d. Mobility: Ability to change and control body position- 1. Completely immobile (does not make even slight changes in body or extremity position without assistance). e. Nutrition: Usual food intake pattern- 3. Adequate (Eats over half of most meals). f. Friction and Shear - 1. Problem (Requires moderate to maximum assistance in moving). A review of the Braden Skin Risk Assessment Scale dated April 14, 2025, has a total score of 12, which meant the resident is high risk of developing pressure injury. A review of Resident 3's Order Summary Report, active orders as of April 23, 2025, indicated, Right Elbow stage 4 pressure injury: Cleanse with Normal Saline, pat dry with gauze, apply MEDIHONEY AND CALCIUM ALGINATE, pad with ABD and wrap with kerlix for 21 days and PRN for soiled or dislodged dressing .Start date 4/15/2025 Further review of the Order Summary Report, active orders as of April 23, 2025, did not indicate any treatment orders for the blister on the right elbow, noted during re-admission on [DATE]. On April 23, 2025, at 10:38 a.m., during a concurrent wound care observation for Resident 3 and interview with Treatment Nurse (TN) 1 and Licensed Vocational Nurse (LVN) 3, TN 1 stated Resident 3 had a Stage 4 pressure injuries on her right elbow and left heel. Resident 3's right arm was offloaded on a rolled bed sheet. Resident 3 had an open wound on her right elbow, circular in shape, which measured approximately three centimeters (cm-a unit of measurement) in length and three cm in width, the wound bed was pink, and the bone was exposed. On April 23, 2025, at 12:55 p.m., during an interview, TN 1 stated he received a report from a Certified Nurse Assistant (CNA) on April 15, 2025, that Resident 3's right elbow was wrapped with a bandage. TN 1 stated he assessed Resident 3's right elbow after he removed the bandage and noted that Resident 3 had a Stage 4 pressure injury on her right elbow. TN 1 stated if Resident 3's right elbow was wrapped when she was re-admitted to the facility on [DATE], the staff should have assessed the skin underneath the bandage. On April 24, 2025, at 3:22 p.m. during a concurrent interview with Registered Nurse (RN) 4 and record review of Resident 3's medical record, RN 4 stated she was familiar with Resident 3. RN 4 stated Resident 3 was re-admitted to the facility on [DATE], and she stated the resident's right elbow was wrapped with kerlix and an ACE bandage (compression bandage). RN 4 stated Resident 3's right elbow had a blister on it, the size of a ping-pong ball. RN 4 stated she did not document it because the blister was intact. RN 4 stated she should have documented the presence of the blister, notified the doctor and she should have obtained a treatment order for the right elbow blister. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On April 25, 2025, at 12:20 p.m., during an interview, RN 3 stated the licensed nurses are expected to assess residents from head to toe, upon admission or re-admission, and document skin issues. RN 3 stated if the assessment was not documented then it was not done. RN 3 stated RN 4 should have unwrapped Resident 3's bandage on the right arm, conducted an assessment, measured the pressure injury, notified the doctor, obtained a treatment order and documented in Resident 3's medical records. RN 3 stated wound care should have been provided to prevent the wound from worsening. On May 12, 2025, at 10:50 a.m., during a telephone interview, LVN 5 stated she was familiar with Resident 3. LVN 5 stated she was the TN after Resident 3 returned from the hospital. LVN 5 stated Resident 3's right arm was wrapped and had a sling, but Resident 3 did not want her to check her right elbow. On May 12, 2025, at 12:18 p.m., during a concurrent interview, TN 2 stated every licensed nurse should be able to document and describe any skin problems they identified, notify the doctor and obtain a treatment order. TN 2 stated it was important to document skin assessments to keep track of the progress of any wounds. On May 12, 2025, at 1:00 p.m., during an interview, the Director of Nursing (DON) stated if Resident 3 had a blister on her right elbow when she was re-admitted , there should be an assessment, a treatment order and a care plan. The DON stated a blister is cleansed with normal saline, patted dry and a dressing is placed over it to protect it from popping. A review of the facility's policy and procedure titled Initial Nursing Assessment and Re-Assessment dated August 2019 indicated .It is the policy to assess residents upon admission and re-admission to the facility . upon admission, the licensed nurse will conduct a head to toe assessment of resident .Any change in the patient's condition shall require an immediate reassessment with changes in the plan of care reflecting the change in condition .All data collected shall be recorded in the nursing assessment record and shall be available to all disciplines involved in the care of the patient . A review of the facility's policy and procedure titled Skin Breakdown, Prevention and Management dated December 2017 indicated .Upon admission or when a resident is identified to have a non-pressure skin discoloration or skin breakdown, the licensed nurse will contact the attending independent licensed practitioner .for any sites or area that requires any form of treatment .The licensed nurse assigned to the resident will assess, evaluate and initiated a change of condition nursing documentation .Initial wound assessment will be documented on the nursing admission assessment .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the proper procedure in removing blockage of the gastronomy tube (G-tube a tube placed through the abdominal wall directly into the stomach, typically for feeding purposes), in accordance with the policy and procedure for one of three sampled residents (Resident 2). This failure had the potential to negatively impact the resident's ability to receive nutrition, hydration and medication. Findings: A review of Resident 2's medical record indicated he was admitted to the facility on [DATE], with diagnoses which included dysphagia (difficulty swallowing) with G-tube. A review of Resident 2's Nurses Note, dated April 12, 2025, at 5:03 a.m. written by Licensed Vocational Nurse (LVN) 1, indicated .Charge nurse went in to try and flush G-tube with water and when charge nurse noticed that the tubing was clogged she then attempted to unclog the tube and in the process of trying to get the tube unclogged a small bubble popped about halfway down the tubing and and (sic) ripped a hole in it. Charge nurse went and let RN know and she came and assessed the tubing and agreed to send resident out for new tubing. Charge nurse then contacted Primary Ambulance for transportation to Parkview Community hospital. EMTs did arrive 30 minutes later to pickup (sic) resident and charge nurse did call and speak to residents (sic) mother and let her know the current situation . A review of Resident 2's GACH medical record titled .History and Physical dated April 12, 2025, indicated . Patient was seen from (name of skilled nursing facility) due to them noticing holes in his G-tube . On April 18, 2025, at 11:18 a.m., during a telephone interview, Registered Nurse (RN) 2 stated LVN 1 notified her that Resident 2's G-tube was not working. RN 2 stated she notified the MD and obtained an order to transfer Resident 2 to the emergency room. On April 18, 2025, at 11:30 a.m., during a telephone interview, LVN 1 stated she was familiar with Resident 2. LVN 1 stated on the day Resident 2 was sent to the GACH, she heard an alarm and when she checked, it came from Resident 2's G-tube pump. LVN 1 stated the screen of the G-tube pump indicated the G-tube was clogged. LVN 1 stated she paused the feeding and tried to flush the tube with warm water, but it did not work. She then applied A & D ointment (skin moisturizer and protectant) to milk (removal of the contents by compressing the tube with the fingers and moving them along the course of the tube) the G-tube. LVN 1 stated as she was milking the G-tube, a small bubble formed in the tubing, it popped and resulted in a tear on the G-tube. LVN 1 stated she clamped the G-tube and notified the RN. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 22, 2025 at 10:57 a.m., during an interview with LVN 2 and a record review of Resident 2's Nurses Note, LVN 2 stated if a resident's G-tube was clogged, he would try flushing with 50 to 100 mL (milliliter - a unit of measurement) of warm water and gently squeeze the G-tube to loosen the clog and if that did not work, he would contact the doctor and obtain an order to send the patient out to the hospital. LVN 2 stated LVN 1 forced flush Resident 2's G-tube. LVN 2 stated if a bubble formed in the G-tube while unclogging it, the nurse should stop because the G-tube might burst. On April 25, 2025, at 12:20 p.m., during an interview, RN 3 stated the licensed nurses are expected to try to unclog a G-tube by flushing with warm water using a pulsating motion. RN 3 stated they should not use force, massage the tube, or apply A&D ointment. RN 3 stated if the clog would not clear, the licensed nurses must notify the doctor and should obtain an order to send the resident to the hospital for a G-tube replacement. RN 3 stated LVN 3 should have stopped unclogging Resident 2's G-tube when the bubble appeared to prevent the G-tube from tearing. On May 12, 2025, at 1:00 p.m. during an interview, the Director of Nursing (DON) stated when a G-tube is clogged, the licensed nurses should flush it with normal saline. If that method is ineffective, they should initiate a change of condition, notify the doctor and follow the doctor's order. A review of the facility's policy and procedure titled Maintaining Patency of a Feeding Tube (Flushing) dated January 2018 indicated .If the feeding tube is clogged .Check tubing for kinks .Add 30 mL (or prescribed amount) warm water to the syringe .With water in the syringe, apply a gentle back and forth motion with the plunger to try to dislodge the clog .Report complications promptly to the supervisor and the Attending Physician .