

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 05/01/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from physical abuse, when two facility staff witnessed one Certified Nursing Assistant (CNA 1) roughly pushed one of three sampled residents (Resident 1) multiple times, to prevent resident from getting up from bed. Resident 1 has severe cognitive impairment.</p> <p>This failure could very likely result in Resident 1 experiencing increased anxiety and distress which negatively impact Resident 1's psychosocial, and mental well-being.</p> <p>Findings:</p> <p>On May 1, 2025, at 8:55 a.m., an unannounced visit was made to the facility to investigate an allegation of abuse.</p> <p>A review of Resident 1's record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), anxiety, Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), depression, and cognitive communication deficit.</p> <p>A review of Resident 1 ' s BIMS (Brief Interview for Mental Status - an assessment tool) score was 1, which meant the resident has severe cognitive (thinking) impairment.</p> <p>A review of Resident 1's care plan initiated on February 18, 2025, indicated:</p> <ul style="list-style-type: none"> - Focus: hx (history) of anxiety mb (manifested) WANDERING WITHOUT PURPOSE; - Goal .Resident identifies strategies to reduce anxiety; - Interventions .Interact with resident in a peaceful manner . <p>A review of Resident 1 ' s progress notes, dated April 22, 2025, indicated, Around 1930 (7:30 p.m.) two CNAs reported to RN (Registered Nurse) that they noticed the assigned sitter for (Room number of Resident 1) was allegedly not allowing resident to stand up from bed and shoving resident down. RN immediately assessed resident and noted redness to residents (sic) face. Administrator informed .</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 1, 2025, at 9:55 a.m., Resident 1 was interviewed. Resident 1 did not remember anything that happened on April 22, 2025.</p> <p>On May 1, 2025, at 10:21 a.m., during an interview, CNA 2 stated on April 22, 2025, around 7-7:30 pm, as he was sitting at the nursing station, directly across from Resident 1 ' s room, he witnessed Resident 1 trying to get up to stand by his bed, and CNA 1 shoved him back in bed by pushing down on his shoulders, roughly, and as a result Resident 1 fell back on his bed, on the mattress. He stated this happened a couple of times; so, he went in to see the resident. CNA 2 stated Resident 1 had redness spots on his face and his left face cheek was swollen. CNA 2 stated per facility policy no abuse was allowed towards any resident.</p> <p>On May 1, 2025, at 12:05 p.m., during a telephone interview, CNA 3 stated she was the sitter for Resident 1 ' s roommate on April 22, 2025. CNA 3 stated she witnessed an incident between CNA 1 and Resident 1. CNA 3 stated she witnessed CNA 1 push Resident 1 roughly and the resident fell back on his bed. CNA 3 stated Resident 1 was yelling stop and help. CNA 3 stated she saw Resident 1 with redness on his face and some swelling on the left side of the face (the cheek area). CNA 3 stated she heard slapping noises, but did not see the slapping. CNA 3 also stated Resident 1 ' s did not have redness and swelling on his face earlier in the shift. CNA 3 stated no abuse of any kind is allowed towards any resident at the facility, including roughness or physical abuse.</p> <p>On May 1, 2025, at 1 p.m., an interview was conducted with the facility ' s Administrator (ADM). The ADM stated the facility conducted its own follow-up investigation regarding the allegation of abuse involving Resident 1. The ADM stated the facility concluded the allegation was substantiated because CNA 1 was rough with Resident 1, as witnessed by two other CNAs. The ADM stated facility has a strict policy, and no rough handling of residents is allowed.</p> <p>On May 1, 2025, at 2:56 p.m., a telephone interview was conducted with the Registered Nurse (RN). The RN stated he was informed on April 22, 2025, by CNA 2 that the CNA witnessed CNA 1 being rough with Resident 1. RN 1 stated he assessed Resident 1 and observed redness on his left side of the face and redness and swelling on the left face cheek. RN 1 stated staff was not allowed to be rough or abuse residents of the facility.</p> <p>A review of the facility policy and procedure titled, Abuse and Neglect Prohibition Policy, dated June 2022, indicated, .It is the facility ' s policy to prohibit abuse, mistreatment .Purpose .To ensure that facility staff are doing all that is within their control to prevent occurrences of abuse, mistreatment .Abuse is defined as the willful infliction of physical pain, injury, or mental anguish, or the willful deprivation by a caretaker of services which are necessary to maintain physical or mental health including the following .Physical abuse includes hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment .</p>		