

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 05/27/2025
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide wound treatment for one of two residents' (Resident 4) left lower extremity open wound for three days since admission to the facility.</p> <p>This failure of delayed provision of wound treatment can lead to serious complications like sepsis, infection and even amputation.</p> <p>Findings:</p> <p>A review of Resident 1's admission Record, indicated the resident was re-admitted to the facility on [DATE], with diagnoses which included non-pressure ulcer of other part of the left foot and ankle and peripheral vascular disease (reduced circulation of blood to a body part).</p> <p>A review of Resident 4's general acute care hospital (GACH) document titled Discharge Summary, dated May 1, 2025, indicated Resident 5 was admitted on [DATE], with open wound to her lower extremity and was discharged to nursing home (skilled nursing facility) on May 1, 2025.</p> <p>A review of Resident 4's general acute care hospital notes (GACH) titled PATIENT PROGRESS NOTES, dated May 1, 2025, indicated Resident 4 had open wounds on her left lower and posterior leg and left foot.</p> <p>A review of Resident 4's skilled nursing facility (SNF) Nursing admission Assessment, dated May 1, 2025, indicated Resident 4 had a skin breakdown on her left lower leg.</p> <p>Further review of Resident 4's admission assessment included a Braden Skin Risk Assessment with a total score of 18, which meant Resident 4 was considered mild risk for pressure ulcer.</p> <p>A review of Resident 4's electronic Physician's Orders, did not indicate a wound treatment was ordered for Resident 4's left lower extremity open wound on May 1 to 3, 2025</p> <p>A review of Resident 4's Treatment Administration Record (TAR), for the month of May 2025, indicated no documentation that wound treatment was provided to Resident 4's left lower extremity open wound on May 1 to 3, 2025.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On May 23, 2025, at 10:16 a.m., during a concurrent interview with Treatment Nurse (TN) 1 and a record review of Resident 4's physician's orders, TN 1 stated there was no treatment order for Resident 1's left lower extremity open wound from May 1-4, 2025. TN 1 stated the admitting Registered Nurse (RN) should have done a skin assessment and communicated with TNs or charge nurses to do a follow up assessment and should have notified and clarified the treatment orders with Resident 5's physician.</p> <p>On May 27, 2025, at 11:23 a.m., during an interview, the Quality Assurance Nurse (QAN) stated Resident 5 was re-admitted from the GACH and the nurses did not put in a treatment order for the resident's left lower extremity open wound. The QAN stated the admitting RN should conduct a full body assessment and get a treatment order so that the other TNs can be made aware of the treatments.</p> <p>On June 4, 2025, at 3:04 p.m., during a telephone interview, RN 5 stated she helped re-admitting Resident 5 on May 1, 2025. RN 5 stated she assessed Resident 5's open wounds, but she did not describe the wound in the medical records.</p> <p>On June 6, 2025, at 2:31 p.m., during a telephone interview, the Assistant Director of Nursing (ADON) stated the RN, or the Desk Nurse were expected to confirm hospital orders with the resident's physician and carry out the orders. If they need clarification with treatment orders, they should confirm it with the physician and if they have not heard back from the physician, then nurses should endorse it to the next shift to follow up. The ADON stated a skin check is conducted for residents on the day of admission.</p> <p>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 and/or skin breakdown, the licensed nurse will notify the independent licensed practitioner for any sites or area that requires any form of treatment .</p>		