

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  07/14/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure routine Norco (narcotic pain medication) was available for one of two residents (Resident 1), when Resident 1 did not receive four doses in June 2025, and nine doses in July 2025. This failure had the potential for Resident 1 to experience psychological distress and unmanaged pain. Findings: On July 14, 2025, at 9:40 a.m., an interview was conducted with Resident 1 in her room. Resident 1 was well-groomed and interviewable. Resident 1 stated she has been at the facility for three years. Stated she has been using Norco for three years, which has been effective for managing her arthritic pain and it is a routine medication for her. Resident 1 stated the Norco is to be ordered 4 days before it runs out and when it is delayed she was always told it's either an issue with the pharmacist, or the doctor did not sign for it. She stated in the past, Norco was pulled from the emergency kit, but it wasn't done because the doctor needed to sign for it. Within the last month, she waited for a day for the medication to arrive. She stated working with the RNA (Restorative Nursing Assistant - specially trained nursing assistant who helps the residents with exercises to improve mobility and strength) has been difficult due to not having her Norco available. She stated this has been an on-going problem. During a review of Resident 1's admission Record, dated July 14, 2025, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with a diagnoses which included chronic pain syndrome, spinal stenosis (narrowing of the spinal canal), and radiculopathy of the lumbar region (compressed nerve root in the lower back). During a review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated May 2, 2025, the MDS indicated a Brief Interview of Mental Status (BIMS - a tool to assess cognitive function of an individual) score of 14 (cognitively intact). During a review of Resident 1's Physician Order, dated April 16, 2025, the Physician Order indicated an order date of April 16, 2025, for Hydrocodone-Acetaminophen (Norco) Oral Tablet 10/325, give one tablet by mouth six times a day for pain management. During a concurrent interview and record review on July 14, 2025, at 10:35 a.m., with the Registered Nurse (RN), Resident 1's Medication Administration Record (MAR), dated June 2025, and July 2025, were reviewed. The MAR indicated missed doses for Hydrocodone-Acetaminophen 10/325 on the following dates and times: June 22, 2025: 0900 (9am), 1300 (1pm), 1700 (5pm), 2100 (9pm); June 23, 2025: 0100 (1am); July 3, 2025: 0900, 1300, 1700, 2100; July 4, 2025: 0100; July 9, 2025: 0900, 1300, 1700; and July 10, 2025: 0100. The RN stated there was no documentation on the MAR for June or July that indicated Resident 1 received the Hydrocodone-Acetaminophen 10/325 on the above noted dates and times. The RN stated Resident 1's missed doses in July were due to waiting on the doctor's signature and she was unsure of the missed doses in June. The RN stated, for a narcotic, the doctor needs to sign the order, and the doctor will contact the pharmacy to electronically reorder the narcotic. The RN stated if there is a delay in reordering the nurse will call the doctor to follow up, and if the medication administration is delayed the doctor is also notified. On July 14, 2025, Resident 1's progress notes were reviewed. The progress note dated 6/22/25 at 1013 (10:13 a.m.) indicated, HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth six times a day for PAIN MANAGEMENT NTE 3G of Acetaminophen in 24H from all sources Medication not available now. The progress noted dated 6/22/25 at 1223 (12:23 p.m.) indicated, HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth six times a day for PAIN MANAGEMENT NTE 3G of Acetaminophen in 24H from all sources Medication not available now. The progress note dated 6/22/25 at 1711 (5:11 p.m.) indicated, HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth six times a day for PAIN MANAGEMENT NTE 3G of Acetaminophen in 24H from all sources follow up with pharmacy. The progress note dated 6/22/25 at 2129 (9:29 p.m.) indicated, HYDROcodone-Acetaminophen Oral Tablet 10-325 MG Give 1 tablet by mouth six times a day for PAIN MANAGEMENT NTE 3G of Acetaminophen in 24H from all sources Medication not on hand. There was no documentation the facility notified Resident 1's physician that Resident 1 did not receive her Norco as ordered. During an interview on July 14, 2025, at 3:30 p.m., with the Pharmacist, the Pharmacist stated Hydrocodone-Acetaminophen 10/325 was reordered on June 18, 2025, and was delivered to the facility on June 22, 2025. The Pharmacist stated Hydrocodone-Acetaminophen 10/325 should have been delivered the following day (June 19, 2025) and there was no documentation indicating why the</p>		