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	09/12/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents were free from abuse when one of five residents (Resident 168) reviewed for abuse was verbally abused by another resident (Resident 10), after Resident 168 asked Resident 10 to lower the volume of his music. Resident 10 verbally threatened Resident 168 and called him derogatory names.The facility failure resulted in Resident 168 feeling threatened by Resident 10, which could negatively impact the resident's psychosocial well-being. Findings:On September 8, 2025, at 11:11 am, a concurrent observation and interview was conducted with Resident 10 in his room. It was noted that loud music could be heard from the hallway. Resident 10 stated there was an incident with Resident 168 and acknowledged that he continues to play his music loud and does not care if it bothers anyone.A review of Resident 10's admission Record dated September 10, 2025, indicated the resident was admitted on [DATE], with diagnoses which included bipolar disorder (mental disorder).A review of Resident 10's History and Physical dated May 8, 2025, indicated that resident's decision-making capacity is intact.A review of the facility Grievance Report dated June 12, 2025, indicated . Resident [Resident 74] stated that roommate [Resident 10] has his TV too loud at night.Residents were not able to come to an agreement. Resident (Resident 74) agreed to move rooms.A review of Resident 10's Activity Note dated July 24, 2025, indicated .Activities Director (AD) spoke with resident at bedside regarding playing music at high volumes while in their room. AD asked resident if they would like headphones for their music. Resident refused and proceeded to ask who sent someone to ask me if I wanted headphones claiming that somebody already tried to talk to him regarding this matter and proceeded to say insults and curse words about them out loud. Resident proceeded to go around the building shortly after the conversation.A review of Resident 10's records indicated there were no additional interventions or care plans in place to address the resident's ongoing loud music behavior.A review of Resident 10's Minimum Data Set (MDS - an assessment tool) dated August 12, 2025, indicated a Brief Interview for Mental Status (BIMS - a tool to assess cognitive function) score was 14 (cognitively intact).On September 8, 2025, at 11:55 a.m. an interview was conducted with Resident 168 in his room. Resident 168 stated Resident 10 played his music too loud, and the loud music has been occurring for months. Resident 168 stated he felt threatened by Resident 10, who had also called him names such as retard. A review of Resident 168's admission Record dated September 10, 2025, indicated an initial admission date of July 19, 2024.A review of Resident 168's History and Physical dated May 8, 2025, indicated decision making capacity is intact.A review of Resident 168's MDS dated [DATE], indicated BIMS score of 15 (cognitively intact).A review of Resident 168's Progress Notes dated August 17, 2025, indicated, .Resident stated that (name of Resident 10) was playing music very loudly. When asked to turn down the music the resident (Resident 10) turn (sic) it up. (Name of Resident 10) turned off the music after some time and began making verbal threats to (name of Resident 168). (name of Resident 10) stated that he was going to be at (sic) (name of Resident 168) .On September 12, 2025, at 11:38 am a concurrent interview and record review were conducted with the AD. The AD stated he informed the Social Services Director (SSD) of Resident 10's refusal of headphones. The AD stated he did not know if any other interventions were implemented to address the loud volume.On September 12, 2025, at 1:10 pm, a concurrent interview and record review was conducted with the SSD. The SSD stated the Grievance Report dated June 12, 2025, addressed the issue by removing the complainant and did not address the loud volume. On September 12, 2025, at 2:46 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 stated if there was a complaint about loud music it should be addressed and care planned. LVN 3 stated it was important to know what interventions should be implemented to address the problem.On September 12, 2025, at 2:48 pm an interview was conducted with the Director of Nursing (DON). The DON stated she was aware of the grievance filed in June and the behavior of the resident (Resident 10) should have been addressed. The DON stated a care plan should have been initiated to implement interventions. The DON stated on August 17, 2025, the resident (Resident 10) played his music loudly, which led to a verbal altercation between the two residents (Resident 10 and Resident 168). The DON stated if there was an intervention or care plan, the altercation on August 17, 2025, could have been prevented.A review of the facility's policies and procedures titled, Abuse and Neglect Prohibition Policy, dated June 2022, indicated, .The following actions to prevent abuse.identifying, correcting, and intervening in situations in which abuse is more likely to occur care planning of residents with needs and behaviors which

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on interviews and record reviews, the facility failed to complete monitoring for a skin related change of condition for one of one resident (Resident 12) reviewed for quality of care.This failure resulted in inconsistent evaluation of the wound and placed Resident 12, who had diabetes (abnormal blood sugar) and peripheral vascular disease (a problem with blood flow), at risk for infection, delayed wound treatment, and worsening of the condition of the left second toe.Findings:A review of Resident 12's admission Record dated September 10, 2025, indicated an admission date of July 20, 2025 with a diagnoses which included peripheral vascular disease and diabetes mellitus.A review of Resident 12's History and Physical dated August 25, 2025, indicated resident can make needs known but cannot make medical decisions.A review of Resident 12's Minimum Data Set (MDS - an assessment tool) dated September 2, 2025, indicated a Brief Interview for Mental Status (BIMS - a tool to assess cognitive function) score was 05 (severe cognitive impairment).A review of Resident 12's Podiatric Evaluation and Treatment Report dated August 18, 2025, indicated .Peripheral Arterial Disease.Trimmed and electrical Debridement with Dremel drill.Nail removal.Left. T1 Avulsion (tearing of body part)/Removal.A review of Resident 12's N Adv - Skin Check dated August 18, 2025, indicated, .Left Dorsum 2nd Digit (Second Toe).description.Avulsion.new wound.onset.New.A review of Resident 12's N Adv - Skilled Evaluation dated August 19, 2025, and August 21, 2025, indicated, .Skin Group.no skin issues.On September 10, 2025, at 12 p.m., a concurrent interview and record review was conducted with the Treatment Nurse (TN). The TN stated Resident 12's skin avulsion on the left second toe was a new skin finding and should have been considered a change of condition. The TN further stated a change of condition should have been documented and monitored to track the progress of the wound.On September 12, 2025, at 10:58 a.m. an interview was conducted with the Director of Nursing (DON). The DON stated the left second toe avulsion was caused by the podiatry treatment on August 18, 2025. The DON stated a change of condition should have been completed right away including monitoring every shift for three days, to determine if the wound is improving or deteriorating.A review of the facility policy and procedure titled, Change in a Resident's Condition or Status, dated January 2018, indicated, .A ‘significant change' of condition.requires interdisciplinary review.The nurse will record.information relative to changes in the resident's medical.condition or status.