

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 10/14/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on interview and record review, the facility failed to develop and revise a comprehensive, person-centered care plan to address transportation needs for one of three sampled residents (Resident 1) reviewed for dialysis. The facility did not complete an interdisciplinary assessment or care plan update when it changed the resident's transportation method for dialysis from a wheelchair-accessible van to a standard vehicle (Uber). As a result, the resident was transported in an inappropriate vehicle that did not accommodate her functional limitations, leading to missed dialysis treatments, hospitalization, and physical injury. Findings: On October 3, 2025, at 1:08 p.m., during an interview, the SSD stated dialysis residents are admitted to the facility with transportation and dialysis appointments already arranged and that she arranged transportation for any make up dialysis days. The SSD stated Resident 1's insurance is accepted by very few transportation companies. The SSD stated they were using a private wheelchair van transportation for Resident 1, but the facility stopped paying and she does not know why. The owner of the private wheelchair van transportation informed her that because he was not getting paid, he could not take Resident 1 to dialysis anymore. The SSD stated the Case Manager (CM) arranged recurrent trips for Resident 1's dialysis appointments via Uber which started the week of September 22, 2025. The SSD stated this was not discussed with Resident 1 nor her family member (FM). The SSD stated it was the corporate office who determined to use Uber because they did not want to pay for wheelchair van transportation. The SSD stated if the resident's insurance does not cover transportation, the resident can pay privately, and if the resident cannot pay, the facility will pay for it. On October 3, 2025, at 4:23 p.m. during a telephone interview with Resident 1's FM, the FM stated the facility was sending Resident 1 to her dialysis appointments via Uber. The FM stated Resident 1 had an operation on her feet and was not supposed to put pressure on her feet and that she needed a lifted van for a wheelchair transfer. The FM stated he had a meeting with the facility on October 1, 2025, and they said they would take care of the transportation, but he did not hear from them. On October 3, 2025, a review of Resident 1's care plan revealed no interventions addressing transportation to dialysis, transfer assistance, or mobility safety. There was no revision to the care plan after the transportation method changed or after the injury occurred. There was no documentation of resident or family participation in developing or revising the care plan regarding transportation method to and from dialysis. Cross refer to F684</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 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that Resident 1 received necessary care and services in accordance with the resident's comprehensive assessment and professional standards of practice when the facility did not conduct a comprehensive interdisciplinary assessment of transportation needs to ensure safe and proper transport to and from dialysis appointments for 1 of 3 sampled residents (Resident 1) reviewed for dialysis. This failure resulted in Resident 1 being transported to dialysis (medical treatment that removes waste products and excess fluid from the blood when the kidneys are unable to) appointments via Uber three times a week, leading to unsafe and uncomfortable transfers from wheelchair to car every dialysis appointment and resulted in missed or delayed dialysis on September 23 and 24, 2025, hospital transfer for dialysis, and continued use of an unsafe transport method. On October 2, 2025, while being transported in a standard vehicle (Uber), the resident sustained a right chest-wall hematoma, soft-tissue swelling, and possible rib fractures, demonstrating that the unsafe practice caused actual serious harm and placed the resident at ongoing risk of further injury or death. The facility continued to use Uber transportation for dialysis through October 9, 2025, after the resident's injury, thereby exposing the resident to an ongoing risk of serious injury or death from missed or delayed dialysis or additional trauma during unsafe transfers. This constitutes Immediate Jeopardy to resident health and safety because the facility's noncompliance caused actual serious harm and presented a continued likelihood of serious injury, harm, or death. On October 10, 2025, the ADM presented an acceptable removal plan which included the following: 1. Resident 1 was assessed by assigned licensed nurse for any adverse effects of being transferred to dialysis using Uber Health (helps patients and clinical staff arrange and schedule transportation services with independent third-party providers) transportation. 2. Resident 1 was also assessed by PT (Physical Therapist) to determine whether Resident 1 can tolerate the car or wheelchair van transportation. 3. The Care Plan was updated to reflect current transportation information for dialysis. 4. A new contract for wheelchair transport was drawn up by the ADM. 5. An ad hoc (impromptu tasks, meetings, or projects that arise suddenly in response to a particular situation) QAPI (Quality Assurance and Performance Improvement - a data-driven and proactive approach used in healthcare facilities to systematically improve the quality of care provided to residents) Committee meeting was held to discuss changes in contracted dialysis transportation services. 6. Inservice training was conducted by DON and/or DSD (Director of Staff Development) with licensed staff regarding use of contracted dialysis transportation. On October 14, 2025, at 2:07 p.m., the immediacy was removed in the presence of the ADM and the DON upon verification of implementation of the removal plan. Noncompliance for F684 remained at the scope and severity of J actual harm that is immediate jeopardy to resident health and safety. Findings: A review of Resident 1's admission Record dated October 3, 2025, indicated Resident 1 was initially admitted to the facility on [DATE], with diagnoses which included type 2 diabetes (high blood sugar), end stage renal disease (permanent kidney failure that requires a regular course of dialysis). A review of Resident 1's Physical Therapy Evaluation and Plan of Treatment, dated September 18, 2025, indicated, .Precautions: fall risk .heel WB (weight bearing) only during transfers .S/P (status after) amputation (removal of the body part) of L (left) 2nd and 3rd toes .A review of Resident 1's Minimum Data Set (MDS - a standardized assessment tool) dated September 22, 2025, indicated the resident is cognitively intact (ability to think effectively) and requires substantial/maximal assistance with sit to stand and chair/bed-to-chair transfer and dependent with wheelchair mobility. A review of Resident 1's Order Summary Report dated October 3, 2025, indicated .Dialysis Center: (name, address and telephone number) Dialysis Days: T-Th-Saturday (Tuesday-Thursday-Saturday) Pick-up time 0415 (4:15 a.m.) chair time 0430 (4:30 a.m.) . was ordered on September 18, 2025. A review of Resident 1's Progress Notes indicated the following: -On September 23, 2025, at 6:30 a.m., Resident 1 missed her dialysis appointment due to transportation. No further explanation was documented. -On September 23, 2025, at 4:58 p.m., the SSD wrote she was informed Resident 1 missed dialysis due to transportation not arriving and she reached out to the transportation who stated that they are no longer transporting Resident 1 due to non-payment from the facility. The SSD reached out to the corporate office regarding non-payment, and she was informed that Resident 1's transportation needs to be provided by a straight Medi-cal (a type of health insurance plan) provider. -On September 24, 2025, at 6:38 a.m., Resident 1 missed the rescheduled dialysis appointment today due to transportation issues. At 9:27 a.m. the resident was transferred to the GACH and at 11:10 a.m.</p>		