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	12/11/2025

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 protect the residents' right to be free from physical abuse by a staff member for one of three residents reviewed (Resident 1) when a Certified Nursing Assistant (CNA) placed a towel over Resident 1's mouth.This failure had the potential to obstruct Resident 1's breathing causing suffocation and the risk of aspiration (inhaling food, liquid, or foreign material into the lungs), and emotional distress.Findings:A review of Resident 1's admission Record indicated he was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (disrupted blood flow to the brain).A review of Resident 1's Minimum Data Set (MDS- a standardized assessment) dated November 3, 2025, indicated he has severely impaired (never/rarely made decisions) capacity to make decisions and dependent with activities of daily living.A review of Resident 1's SBAR (Situation, Background, Assessment, and Recommendation - a structure communication form that helps share information about the condition of a patient) Communication Form and Progress Note dated December 8, 2025, indicated that a CNA (CNA 1) reported an alleged abuse from another CNA (CNA 2) to the resident that occurred on December 6, 2025. Resident 1 was assessed for injuries and was noted to have no issues, and was calm in no distress. Resident 1's physician was notified.On December 11, 2025, at 10:20 a.m., during a concurrent observation and interview, Resident 1 was in his room, lying in bed, with gastric tube feeding (delivering liquid food and medicine directly to the stomach via a tube through the abdominal wall) turned on, alert and awake, non-verbal, and able to mouth words. Resident 1 nodded his head no when asked if a CNA covered his face with a towel.On December 11, 2025, at 11:36 a.m., during a telephone interview, CNA 1 stated on December 6, 2025, between 8:00 p.m. to 9:00 p.m., he was charting outside Resident 1's room when he heard the resident grunting. CNA 1 stated he went to Resident 1's room and found CNA 2 with the resident. CNA 1 stated he asked CNA 2 if she needed help and she said yes. CNA 1 stated as he was helping CNA 2, she threw a towel over Resident 1's face and told the resident be quiet. CNA 1 stated he quickly removed the towel and told CNA 2 that if you tell Resident 1 about what you are going to do, he will cooperate, and you do not treat people like that.On December 11, 2025, at 12:46 p.m., during a telephone interview, CNA 2 stated on December 6, 2025, she was changing Resident 1 and CNA 1 asked her if she needed help. CNA 2 stated she always wears a mask when she provides care to residents, but at that time she didn't have a mask and couldn't find one. CNA 2 stated Resident 1 was coughing so she placed a small towel over Resident 1's mouth to protect herself. CNA 2 stated the towel was on the residents' mouth for at least one minute and Resident 1 removed the towel himself.On December 11, 2025, at 1:11 p.m., during an interview, the Director of Staff Development (DSD) stated during their investigation, CNA 2 mentioned that Resident 1 was coughing, saliva was coming out of his mouth, and she did not have a mask on at that time, so she covered Resident 1's mouth with a towel to prevent the resident from coughing. The DSD stated CNA 2 should have used a mask to protect herself. The DSD stated it is unacceptable to place a towel over a residents' mouth. On December 11, 2025, at 2:45 p.m., during an interview with the Director of Nursing and the Administrator (ADM), the ADM was asked if it was acceptable when CNA 2 placed a towel over Resident 1's mouth to which the ADM stated, it is not acceptable, you don't put a towel over a patient's mouth .A review of the facility's policy and procedure titled Abuse Prevention Program dated January 2018, indicated .Our residents have the right to be free from abuse .this includes but is not limited to .physical abuse .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure an allegation of physical abuse involving one of three residents reviewed, Resident 1, was reported to the California Department of Public Health (CDPH), not later than two hours after the allegation was made.This failure resulted in a delay in an investigation being started and had the potential to place Resident 1 and other residents at risk of harm from further abuse. Findings:On December 8, 2025, CDPH received a report from the facility of an allegation of abuse by a staff member involving Resident 1 which occurred on December 6, 2025. The allegation indicated that a Certified Nursing Assistant (CNA) placed a towel over the resident's head and mouth.A review of Resident 1's admission Record indicated he was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (disrupted blood flow to the brain).A review of Resident 1's H&P (history and physical) Note dated November 21, 2024, indicated the resident's decision-making capacity fluctuates.A review of Resident 1's SBAR (Situation, Background, Assessment, and Recommendation - a structure communication form that helps share information about the condition of a patient) Communication Form and Progress Note dated December 8, 2025, indicated a CNA (CNA 1) reported an alleged abuse by another CNA (CNA 2) involving Resident 1 which occurred on December 6, 2025. Resident 1 was assessed for injuries or wounds and was noted to have no issues. Resident 1 was calm and not in distress. Resident 1's physician was notified.On December 11, 2025, at 11:36 a.m., during a telephone interview, CNA 1 stated on December 6, 2025, between 8:00 p.m. to 9:00 p.m., he was charting outside Resident 1's room when he heard the resident grunting. CNA 1 stated he went to Resident 1's room and found CNA 2 with the resident. CNA 1 stated he asked CNA 2 if she needed help and she said yes. CNA 1 stated he saw CNA 2 throw a towel over Resident 1's face and told the resident be quiet. He removed the towel and told CNA 2 that if you tell Resident 1 what you are going to do he will cooperate with you, and you do not treat people like that. CNA 1 stated he did not report the incident to a supervisor because he wanted to speak to the Director of Staff Development (DSD) and Nurse Educator himself. CNA 1 stated he reported this incident on December 8, 2025. CNA 1 stated he was confused about the reporting timeframe, he thought he had 48 hours to report. CNA 1 stated allegations of abuse should be reported immediately, within two to 24 hours.On December 11, 2025, at 1:11 p.m., during an interview, the DSD stated the expectation for staff is if they see or hear something wrong, if they believe it to be abuse or not, is to report it to their supervisor so that it can be reported to the Long-term Care Ombudsman, CDPH, and the facility can initiate an investigation. The DSD stated CNA 1 reported the abuse allegation involving Resident 1 on December 8, 2025, and that the incident occurred on December 6, 2025. The DSD stated 48 hours had passed before CNA 1 reported the incident and CNA 1 should have reported the incident right away on December 6, 2025.On December 11, 2025, at 2:45 p.m., during an interview with the Director of Nursing and the Administrator (ADM), the ADM stated abuse allegations are supposed to be reported in two hours. The ADM stated CNA 1 should have reported the alleged abuse to the Registered Nurse or immediate supervisor when it happened and he did not.A review of the facility document titled ELDER ABUSE DEPARTMENT OF JUSTICE TRAINING ACKNOWLEDGMENT signed by CNA 1 on November 3, 2025, indicated .I acknowledge that I have watched the Elder Abuse Training and understand compliance with the reporting requirement is mandatory. I have been notified of my obligations as mandated reported .A review of the facility's policy and procedure titled Abuse Prevention Program dated January 2018, indicated, .As part of the resident abuse prevention, the administration will .Investigate and report any allegations of abuse within timeframes as required by federal requirements .