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	01/23/2026

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide copies of financial records upon request within two business days after receiving the request from the Long-Term Care Ombudsman (LCTO- an advocate who assists residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences) on behalf of the resident, for one of six sampled residents, Resident 2.This failure is a violation of Resident 2 and the resident's representative's rights.Findings: A review of Resident 2's medical record indicated the resident was admitted to the facility on [DATE], with diagnoses which included history of transient ischemic attack (temporary blockage of blood flow to the brain causing stroke-like symptoms) and vascular dementia (decline in thinking skills caused by restricted blood flow to the brain). Resident 2 is self-responsible.A review of the Resident 2's Minimum Data Set (an assessment tool) dated January 1, 2026, indicated he has the capacity to understand and make decisions.On January 9, 2026, at 12:07 p.m., during an interview, the Business Office Manager (BOM) stated she provides any financial information requested by the residents or their responsible parties immediately within 10-15 minutes. If the person requesting is not the responsible party, she will ask the resident for consent, and they have to sign a form. During the same interview, a concurrent record review of the BOM's e-mail was conducted with the BOM. The BOM stated she received an email from the LTCO on December 24, 2025, requesting Resident 2's report of his trust account, any representative payee documents on file in the last 12 months, his financial summary of his coverage at the facility and any share of cost. Attached to the email was a consent form signed by Resident 2. The BOM stated she has 24 hours to respond to any requests of financial records and she fulfills the request the next business day. The BOM stated she should have responded and fulfilled the request on December 26, 2025, and it has been 12 days since the request was made. On January 12, 2026, at 1:01 p.m., during a telephone interview, the Administrator stated the BOM should respond and fulfill financial record requests as soon as possible.A review of the facility's policy and procedure titled, Access to Personal and Medical Records dated January 2018, indicated, .Each resident has the right to access and/or obtain copies of his or her personal and medical records upon requests .The resident may obtain a copy of his or her personal or medical record as soon as practicable up to 30 days from date of written request . the resident or his/her legal representative, may grant others the right to access the resident's records if such request is made in writing and identifies the information that is to be released and to whom information is to be released .Representatives of the Office of State Long-Term Care Ombudsman may examine a resident's medical, social and administrative records in accordance with state law .

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

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 01/23/2026
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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, for four of four sampled residents, Residents 2, 3, 4, 5, the residents and/or their responsible party were notified of payor changes when the residents were changed from Medi-cal to private pay. This failure is a violation of Residents 2, 3, 4, 5 and/or their responsible parties of resident's rights.Findings:A review of Resident 2's medical record indicated the resident was admitted to the facility on [DATE], with diagnoses which included history of transient ischemic attack (a temporary blockage of blood flow to the brain) and that he is self-responsible.A review of Resident 2's Minimum Data Set (MDS- an assessment tool) dated January 1, 2025, indicated the resident's cognitive function is intact.A review of Resident 2's Census tab in PointClickCare (PCC - an electronic record software) indicated the resident's primary payer is Private Pay (paying out-of-pocket with personal money rather than insurance) effective January 1, 2026. Resident 2's primary payer was Medi-Cal IEHP before January 1, 2026.A review of Resident 3's medical record indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia and that he is self-responsible.A review of Resident 3's MDS dated October 19, 2025, indicated the resident's cognitive function is intact.A review of Resident 3's Census tab in PCC indicated the resident's primary payer is Private Pay effective January 1, 2026. Resident 3's primary payer was Medi-Cal IEHP before January 1, 2026.A review of Resident 4's medical record indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia and her family member was the responsible party.A review of Resident 4's MDS dated November 9, 2025, indicated the resident is rarely/never understood and she had moderately impaired cognitive function.A review of Resident 4's Census tab in PCC indicated the resident's primary payer is Private Pay effective January 1, 2026. Resident 4's primary payer was Medi-Cal IEHP before January 1, 2026.A review of Resident 5's medical record indicated the resident was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (temporary or permanent brain dysfunction cause by chemical imbalances).A review of Resident 5's MDS dated December 14, 2025, indicated the resident cognitive function is moderately impaired.A review of Resident 5's Census in PCC indicated the resident's primary payer is Private Pay effective January 1, 2026. Resident 5's primary payer was Medi-Cal IEHP before January 1, 2026.On January 9, 2026, at 12:07 p.m., during an interview with the Business Office Manager (BOM) and record review of Resident 2's administrative record, the BOM stated Resident 2's current primary payor was private pay and the change was initiated on December 31, 2025, by the Director of Finance (DOF) who is from the corporate office. The BOM stated she was not aware of the change and the reason for the payor change.During the same interview, the BOM called the Accounts Receivable Director (ARD). The ARD stated the BOM, Administrator (ADM) or the Social Service Director (SSD) is supposed to inform the residents about becoming private pay.On January 9, 2026, at 3:41 p.m., during a concurrent observation and interview, Resident 2 was in his room, lying in bed, alert, awake and conversant. Resident 2 stated he was not aware that he is currently paying privately for his stay in the facility, he does not know how much it cost and no one talked to him about these things.On January 9, 2026, at 3:45 p.m., during a concurrent observation and interview, Resident 3 was in his room, lying in bed, alert, awake and conversant. Resident 2 stated he was not aware that he is currently paying privately for his stay in the facility, he does not know how much it costs and no one talked to him about any of these.On January 9, 2026, at 3:47 p.m., during a concurrent observation and attempt to interview, Resident 4 was in her room, lying in bed and her eyes were closed. Resident 4 did not respond when her name was called.On January 12, 2026, at 9:24 a.m., during an (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview, the Social Service Assistant (SSA) stated the BOM is responsible for any payor changes and the BOM is supposed to sit with the resident and let them know of any changes. The SSA stated she never dealt with any payor changes for any residents in the facility.On January 12, 2025, at 11:00 a.m., during a concurrent observation and interview, Resident 5 was in the back dining room, sitting in his wheelchair, alert, awake and conversant. Resident 5 stated he was not aware he was paying privately for his stay in the facility, he does not know how much it cost and no one talked to him about any of these.On January 12, 2026, at 11:41 a.m., during an interview with the BOM and record review of Resident 3, 4, and 5's Census tab in PCC, the BOM stated her department is responsible for notifying the residents and their responsible parties for payor changes by providing a notice of insurance change letter. The BOM stated the DOF initiated the payor changes for Resident 3, 4 and 5 on December 31, 2025. The BOM stated the DOF did not inform her about any of the payor changes for Residents 3, 4, and 5.On January 12, 2026, at 1:01 p.m., during a telephone interview, the ADM stated the BOM is supposed to give a notice of change for payor status to the residents. The ADM stated he was not aware of the changes that the corporate office made for Residents 2, 3, 4 and 5.On January 12, 2026, at 1:10 p.m., during a telephone interview, the DOF stated the BOM, SSD and sometimes ADM, should be responsible for explaining payor changes to the residents, document what they have done and the decisions that were made in the facility. The DOF stated Residents 2, 3, 4 and 5 were reviewed for share of cost and they were over the Medi-Cal limit and the Medi-Cal caseworker advised to make them private pay.On January 21, 2026, at 3:10 p.m., during a telephone interview with Resident 3's responsible party (RP), the RP stated Resident 3 has an account with the facility for incidentals. The RP stated she did not get any notification from the facility about a payor change from Medi-Cal IEHP to private pay and she does not know how much it costs.On January 23, 2025, at 1:16 p.m., during an interview, the ADM stated the BOM is to report any payor changes during their stand-up meeting and initiates the notification for the residents and family before the effective date and no later than the effective date. The ADM stated the BOM did not report any payor changes.On January 27, 2026, at 2:56 p.m., during a telephone interview, the DOF stated she did not receive any Medi-Cal recommendation to change Residents 2, 3, 4 and 5's primary payer to private pay. The DOF stated the Medi-Cal caseworkers discuss it either by phone or through the Medi-Cal portal. When asked who made the decision to change Residents 2, 3, 4 and 5's primary payor to private pay, the DOF stated that it is decided at the facility level.A review of the facility's policy and procedure titled, Pay Source Conversion dated December 2018, indicated .To ensure a viable pay source is determined and proper steps are taken when there is a conversion from one primary pay source to another .The Social Services department is responsible for notifying the family of non-coverage and anticipated payment. The Business office is responsible for ensuring billing and collections when a resident converts to another pay source .Procedure .Medicaid /Medicaid Pending to Private Pay .Notify the Administrator and Social Services that the Medicaid application/reapplication was denied .Contact should be made with the responsible party and Social Service should obtain a new Pay Source Acknowledgement . The resident and/or responsible party must be informed of their financial obligations at that time .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to protect the residents' rights to be free from sexual abuse by another resident and verbal abuse by a staff member for two of the ten residents reviewed (Resident 1 and Resident 7) when: 1.For Resident 1, staff witnessed a male resident (Resident 2) touching Resident 1's breast with one hand and trying to raise Resident 1's shirt up with the other hand; and This failure has the substantial probability of causing Resident 1 to experience anxiety, emotional distress, or fear of recurrence of the sexual abuse which could subsequently lead to decreased engagement in social activities by Resident 1. 2. For Resident 7, another resident (Resident 9) witnessed the CNA (certified nurse assistant) verbally abused Resident 7, by telling Resident 7 to shut up when the resident was crying. This failure has the substantial probability of causing Resident 7 to experience anger, feeling of worthlessness, and inability to trust staff which could subsequently lead to withdrawal from social interaction. Findings:1. A review of Resident 1's admission record indicated Resident 1 was readmitted to the facility on [DATE], with diagnoses which included dementia (condition affecting brain function, memory, and thinking skills), Alzheimer's (brain disorder affecting memory and cognitive functions), and major depressive disorder (persistent loss of interest/pleasure).A review of Resident 1's History and Physical completed on October 6, 2025, indicated Resident 1 did not have the capacity to make decisions.A review of Resident 1's psychiatric (a medical practitioner specializing in the treatment of mental illness) note dated December 23, 2025, indicated, .History.the patient frequently poses safety awareness problems.The patient has shown confusion, disorganization, disorientation, and a noticeable decline in cognitive function.her ability to do domestic task is impaired and is dependent on others.A review of Resident 1's BIMS (brief interview for mental status- cognitive screening tool) score dated December 28, 2025, indicated a score of 3, a severe problem with thinking or memory.A review of the SBAR (Situation, Background, Assessment, Recommendation) dated January 18, 2026, indicated, .resident (Resident 1) was touch (sic) inappropriately by another resident (Resident 2) .on 1/18/2026.family notified.Primary care Clinician notified.On January 21, at 9:36 a.m., during a concurrent observation and interview, Resident 1 was observed alert in bed covered with a sheet. Resident 1 stated she does not remember her breast being touched by another resident.On January 21, 2025, at 11:17 a.m., an interview was conducted with CNA 4. CNA 4 reported that on Sunday, January 18, 2025, at 4 p.m., she went outside to the smoking patio for a 10-minute break. During this time, she heard Resident 1 saying no, no, no and observed Resident 2 touching Resident 1's breast with one hand while using the other hand to raise Resident 1's shirt. CNA 4 noted that there were no other residents present and no staff supervising the 4 p.m. smoke break. She (CNA 4) subsequently removed Resident 1 from the situation and reported the incident to the abuse coordinator.On January 22, 2026, at 1:30 p.m., a concurrent observation and interview was conducted with Resident 2 (alleged abuser). Resident 2 was observed sitting in bed alert, oriented, and well-groomed accompanied by a sitter (trained staff member assigned to provide continuous bedside supervision). When asked about the incident occurring on January 18, 2026, Resident 2 stated he was on the smoking patio when Resident 1 came and parked her wheelchair next to him. Resident 2 stated Resident 1 held his hand and kissed it. Resident 2 stated he did not touch Resident 1, she touched him. Resident 2 stated he did not touch Resident 1 breast nor her shirt. Resident 2 stated a nurse walked up and took Resident 1 away from him. Resident 2 stated there was no facility staff supervising the smoking patio at that time.A review of Resident 2's admission record indicated Resident 2 was readmitted into the facility on November 19, 2025, with diagnoses which (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included end stage renal disease (permanent kidney failure), nicotine dependence (compulsive need for nicotine), and absence of right leg above knee.A review of Resident 2's BIMS dated November 25, 2025, indicated a score of 15, which meant normal thinking.A review of Resident 2's history and physical that was completed on January 7, 2026, indicated Resident 2 had the capacity to make decisions.A review of Resident 2's psychiatric note dated January 21, 2026, indicated .psychiatrist consult f/u (follow up) due to what the patient did to another resident.he stated that (named resident) was the one who started it by holding both of his hands and kissing them. He felt that what she did was an invitation and started fonding (sic) her.A review of Resident 2's care plan related to suspected inappropriate touching of another patient initiated on January 18, 2926, indicated an intervention which included implementation of increased supervision.A review of the five-day follow-up report of the facility related to the alleged sexual abuse involving Resident 1 and Resident 2 dated January 23, 2026, indicated, .The aggressor was witness by staff touching the Victim's breast. Evidence suggests that the allegation of sexual abuse occurred. Our facility continues with discharge planning efforts for the Aggressor and will continue to provide 1:1 monitoring to prevent occurrences.On January 22, 2026, at 3:33 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility process for handling sexual abuse includes separating the victim and the perpetrator, ensuring safety for the victim, assessing, notifying the family, physician, law enforcement, and state agencies. The DON stated Resident 1 is a dependent resident requiring supervision and should not have been outside on the smoke patio without supervision.The facility policy titled Abuse Prevention Program, dated January 2018, indicated .residents have the right to be free from abuse.This includes sexual.verbal abuse .as part of the resident abuse prevention, the administration will: protect our residents from abuse by anyone including facility staff, other residents.develop and implement policies and procedures to aid our facility in preventing abuse.of our residents.implement measures to address factors that may lead to abusive situations.identify and assess all possible incidents of abuse.investigate.any allegations of abuse.2.On January 21, 2026, at 9:02 a.m., a concurrent observation and interview was conducted with Resident 7. Resident 7 was observed alert, in bed covered with a sheet. Resident 7 was able to respond to verbal introductions but was not interviewable.A review of Resident 7's admission record indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which included traumatic brain injury (disruption of the brain's normal function), Parkinson (progressive movement disorder), and psychosis (loss of contact with reality).A review of Resident 7's history and physical completed on March 13, 2025, indicated Resident 7 did not have the capacity to make decisions.A review of Resident 7's BIMS (Brief Interview for Mental Status- cognitive screening tool) dated November 18, 2025, indicated a score of 0 (resident is rarely/never understood).A review of Resident 7's SBAR (Situation, Background, Assessment, Recommendation) dated January 16, 2026, at 5:15 a.m., indicated .alleged verbal abuse 1/16/2026. around 0515 I (Licensed Vocational Nurse 1) was at (named room) when (named resident- Resident 9) came up to me (LVN 1). (named resident-Resident 9) informed me that he saw the CNA (CNA 5) hovering over (named resident in named room) & heard the CNA (CNA 5) tell the patient to shut up.A review of Resident 7's Interdisciplinary Team (a group of professionals from diverse fields who work together collaboratively and independently to achieve a common goal) Post Event Note dated January 16, 2025, at 12:25 p.m., indicated, .intervention.alleged perpetrator was sent home.resident assessed no injury.MD (medical doctor) made aware with order continue monitoring.On January 23, 2025, at 4:55 p.m., an interview was conducted with the witness, Resident 9. Resident 9 stated that on January 16, 2026, around 4:15 a.m., he heard Resident 7 yelling and screaming. Resident 9 stated Resident 7's screams were not his (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	normal screams. Resident 9 stated he got out of bed and stood against the wall across from Resident 7's room. Resident 9 stated he observed CNA 5 standing over Resident 7 stating shut up, shut up. Resident 9 stated he observed CNA 5 leave the room and go to the linen cabinet. Resident 9 stated he reported what he observed to the charge nurse.A review of Resident 9's (witness) admission record indicated Resident 9 was admitted to the facility on [DATE], with diagnoses which included myocardial infarction (heart attack), acute kidney failure (kidney injury), and pulmonary hypertension (high blood pressure that affects arteries).A review of Resident 9's BIMS (Brief Interview for Mental Status- cognitive screening tool) dated December 6, 2025, indicated a score of 15 normal thinking.Attempted calls were made to reach CNA 5 (alleged abuser for Resident 7) on January 22 and 23, 2026, but the CNA accused of verbally abusing Resident 7 did not return the calls.A review of the five-day follow-up report related to the alleged verbal abuse involving Resident 7 and CNA 5, dated January 21, 2026, indicated, .Immediate Actions .The suspected abuser was suspended .The Victim was examined and showed no signs of injuries .Local Law enforcement was notified .Sheriff on scene attempted to interview the reporting party [Resident 9], but the resident refused. The Sheriff determined that there was no criminal activity .On January 23, 2026, at 6:06 p.m., an interview was conducted with the Administrator (ADM). The ADM stated residents should be in a safe environment at all times and free from verbal abuse.A review of the facility policy titled Abuse Prevention Program, dated January 2018, indicated .residents have the right to be free from abuse.This includes sexual.verbal abuse .as part of the resident abuse prevention, the administration will: protect our residents from abuse by anyone including facility staff, other residents.develop and implement policies and procedures to aid our facility in preventing abuse.of our residents.implement measures to address factors that may lead to abusive situations.identify and assess all possible incidents of abuse.investigate.any allegations of abuse.A review of the facility policy titled Resident Rights, dated January 2018, indicated .Employees shall treat all residents with kindness, respect, and dignity.federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be treated with respect, kindness, and dignity; be free from abuse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a safe environment and adequate supervision were provided for two of four sampled residents (Residents 2 and 3), when Residents 2 and 3 were observed to have smoking paraphernalia kept at bedside. In addition, the facility failed to ensure Resident 2's capability and deficit was assessed to determine the need for assistance and supervision for smoking.These failures had the potential for environmental risk, hazards and accidents resulting in serious burn injuries and/or fire for Residents 2 and 3 and other residents at the facility.Findings:On January 22, 2026, at 1:30 p.m., a concurrent observation and interview was conducted with Resident 2. Resident 2 was observed sitting in bed alert, oriented, and well-groomed, accompanied by a sitter. Resident 2 stated he is a smoker and he keeps his smoking materials in his jacket by the bedside. Resident 2 was observed pulling a red and white pack of cigarettes and a purple lighter from his black jacket pocket. Resident 2 stated he only smokes in the smoking patio.On January 22, 2026, at 2:54 p.m., a concurrent observation and interview was conducted with Resident 3. Resident 3 was observed alert and oriented in a wheelchair at bedside. Resident 3 stated she is a smoker and she keeps her smoking materials in the nightstand drawer. Resident 3 was observed removing one blue lighter and a red pack of cigarettes from the top nightstand drawer. Resident 3 stated she only smokes in the smoking patio.On January 22, 2026, at 3:04 p.m., a concurrent observation, interview, and record review was conducted with the Licensed Vocational Nurse (LVN). The LVN stated residents are not allowed to have smoking materials; only activities personnel are supposed to have resident's smoking materials. During observation, Resident 2 pulled his cigarettes and lighter out of his pocket and showed the LVN. The LVN stated Resident 2 should not have smoking materials with him. The LVN stated there was no documented evidence of a smoking assessment for Resident 2. The LVN stated smoking assessments are conducted on residents who smoke.A review of Resident 2's admission record indicated Resident 2 was readmitted into the facility on November 19, 2025, with diagnoses which included end stage renal disease (permanent kidney failure), nicotine dependence (compulsive need for nicotine), and absence of right leg above knee.A review of Resident 2's smoking assessment dated [DATE], at 11 p.m., indicated.safe smoking evaluation.smokes.No.A review of Resident 2's history and physical completed on January 7, 2026, indicated Resident 2 had the capacity to make decisions.The smoking assessment dated [DATE], at 3:07 p.m., indicated .resident is a safe smoker and performs functions independently. (if this was done after the fact, I would suggest not adding it).A review of Resident 2's smoking assessment dated [DATE], indicated Resident 2 was a non-smoker.There was no documented evidence of a smoking assessment reflecting Resident 2's current status of smoker, until the concurrent observation and interview was conducted with the LVN on January 22, 2026, at 3:04 p.m., confirming the facility allowed Resident 2 to smoke without a valid smoking assessment and without supervision.A review of Resident 3's admission record indicated Resident 3 was admitted into the facility on September 10, 2025, with diagnoses which included chronic obstructive pulmonary disease (inflammatory lung disease), diabetes mellitus (high blood sugar), and major depressive disorder (loss of interest/pleasure).A review of Resident 3's History and Physical which was completed on September 10, 2025, indicated Resident 3 had fluctuating capacity to understand and make decisions.A review of Resident 3's quarterly smoking assessment dated [DATE], indicated, .resident is a smoker.resident is a safe smoker.independent.A review of Resident 3's care plan dated January 15, 2025, indicated, Resident smokes cigarette and independent.goal.resident will smoke safely with supervision.intervention.activity staff will offer resident will keep all smoking materials inside the smoking cart at all (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times staff will give 1 smoke and light the smoke for the resident staff will also supervise all residents.On January 22, 2026, at 3:33 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the following:The facility process for smoking residents includes smoking assessment upon admission and quarterly. if the resident is deemed independent; the resident would be able to keep their cigarettes but not their lighter. Resident 2's smoking assessment dated [DATE], indicated, .safe smoking evaluation.smokes.No. Resident 2 smokes. Resident 2's smoking assessment did not reflect the resident's current smoking status. Resident 2 should not be smoking without an assessment and should not be smoking without supervision.Resident 3's quarterly assessment dated [DATE], indicated, .independent smoker.resident is safe smoker.Independent smokers are allowed to keep their cigarettes and must have activity personnel light their cigarettes. Residents are not allowed to have lighters, so Resident 3 should not have had a lighter at bedside.A review of the facility policy titled Smoking Policy-Residents, dated June 2022, indicated .This facility shall establish and maintain safe resident smoking practices.prior to, or upon admission, residents shall be informed about any limitations on smoking .and the extent to which the facility can accommodate their smoking.any smoking-related privileges, restrictions, and concerns.shall be noted on the care plan.Residents who have independent smoking privileges shall be permitted to keep cigarettes.Residents may not keep even disposable safety lighters.documentation of smoking will be assessed and documented in the smoking assessment.A plan of care will be developed for resident who smokes in the care plan.

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 01/23/2026
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)
F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bedside water pitchers were filled or that fresh water was offered daily to maintain proper hydration for two of seven sampled residents (Residents 1 and 7).This failure has the potential to adversely impact the residents' hydration status.Findings:On January 21, 2026, at 9:08 a.m., a concurrent observation and interview was conducted with Resident 1. Resident 1 was observed alert and oriented, seated in his wheelchair beside the bed. Resident 1's bedside table contained a teal water pitcher which was one-quarter full of water. Resident 1 stated the CNAs would usually refill his water, but this had not been done this morning.On January 22, 2026, at 8:32 a.m., a concurrent observation and interview were conducted with Resident 1. It was noted that Resident 1's water pitcher remained at the same level as observed on January 21, 2026. Resident 1 reported that his water pitcher had not been refilled either yesterday or today.On January 22, 2026, at 12:51 p.m., a concurrent observation and interview was conducted with Resident 7. Resident 7 was observed alert, oriented, dressed, and sitting up in bed while eating lunch. Resident 7's teal pitcher, one-fourth full of water, was observed on the nightstand. Resident 7 stated the CNAs would usually refill her water pitcher. However, she stated her water pitcher had not been filled today.On January 23, 2025, at 8:04 a.m., a concurrent observed and interview was conducted with Resident 7. Resident 7's water pitcher remained at the same level observed on January 22, 2026. Resident 7 stated her water pitcher had not been filled yesterday or today.On January 23, 2026, at 8:39 a.m., a concurrent observation and interview was conducted with the Certified Nurse Assistant (CNA 2), with Resident 7 present. CNA 2 stated that the NOC (night) shift is responsible for filling all residents' water pitchers daily before the end of shift. Resident 7's water pitcher was observed one-fourth full. CNA 2 stated it looks like the NOC shift did not refill Resident 7's water pitcher. Resident 7 confirmed her water pitcher had not been filled yesterday or today.On January 23, 2026, at 8:46 a.m., a concurrent observation and interview was conducted with CNA 2, with Resident 1 present. Resident 1's water pitcher was observed one-fourth full. CNA 2 stated Resident 1's water pitcher looks like the NOC shift did not refill Resident 1's water pitcher. Resident 1 confirmed his water pitcher had not been filled in two days.A review of Resident 1's admission Record indicated the resident was readmitted into the facility on April 20, 2025, with diagnoses which included diabetes mellitus (high blood sugar), chronic kidney disease (kidney damage), and hypotension (low blood pressure).A review of the History and Physical, dated November 24, 2025, indicated Resident 7 had the capacity to make decisions.A review of the care plan dated April 21, 2025, indicated the following: .Resident 1 is continent of bowel and bladder function.Intervention.encourage fluids during the day to promote prompted voiding responses.; .Resident 1 is at risk for protein malnutrition.Intervention.assist and encourage with in-between fluids and snacks.; and .Hyperglycemia.Intervention.encourage hydration.A review of the care plan dated December 7, 2025, indicated, .the resident has an abrasion to left knee.Intervention.Encourage good nutrition and hydration in order to promote healthier skin.A review of Resident 7's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included chronic kidney disease (kidney disease) and malignant neoplasm lower left lung (lung cancer).A review of the BIMS (Brief Interview for Mental Status- an assessment tool) score indicated a score of 11 a moderate problem with thinking.On January 23, 2026, at 6:01 p.m., an interview was conducted with the Administrator (ADM). The ADM stated the facility's process for managing resident water pitchers are for the NOC (night) shift CNAs to replace and refill residents' water pitchers with fresh water daily towards (continued on next page)

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 01/23/2026
NAME OF PROVIDER OR SUPPLIER Riverside Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 8781 Lakeview Avenue Riverside, CA 92509	

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the end of every shift. The ADM stated the NOC shift CNAs should have followed the facility process by changing out pitchers and refilling pitchers daily at the end of each shift. The ADM stated the possible outcomes of not refilling water pitchers could a resident at risk for dehydration.A review of the facility policy titled Resident Hydration and Prevention of Dehydration, dated January 2018, indicated .This facility will strive to provide adequate hydration and to prevent and treat dehydration.Nurses' aides will provide and encourage intake of bedside, snacks and meal fluids, on daily and routine basis as part of daily care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when Licensed Vocational Nurse (LVN) 1 did not wear the appropriate personal protective equipment (PPE - specialized clothing or equipment worn to create a barrier between healthcare workers and potential sources of infection, like blood, body fluids, or other potentially infectious materials) when she entered the room of a COVID-19 (SARS-CoV-2-a highly contagious respiratory disease) positive resident.This failure had the potential to spread COVID-19 to other residents.Findings:On January 8, 2026, at 5:48 a.m., during an observation outside Resident 1's room, there were signs by the door indicating .CONTACT PRECAUTIONS .EVERYONE MUST Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO .Put on gloves before room entry .Put on gown before room entry .DROPLET PRECAUTIONS .EVERYONE MUST .Make sure their eyes, nose and mouth are fully covered before room entry .On January 8, 2026, at 12:25 p.m., during a concurrent observation and interview with LVN 1, LVN 1 was outside Resident 1's room and stated she was going to check Resident 1's blood sugar level. LVN 1 was observed putting on a surgical mask, gown and gloves. She entered the room and checked Resident 1's blood sugar level. LVN 1 stated there were contact and droplet precaution signs outside Resident 1's door because she had COVID-19. LVN 1 stated the signs were posted to be followed so they do not transmit bacteria. LVN 1 stated she was wearing a surgical mask, gown and gloves when she entered Resident 1's room. LVN 1 stated she should have worn an N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) mask and a face shield. On January 9, 2026, at 1:33 p.m., during an interview, the Infection Preventionist Nurse stated LVN 1 should have worn the proper PPE which are gown, gloves, N95 mask and face shield before entering Resident 2's room.On January 12, 2026, at 12:19 p.m., during an interview, the Director of Nursing stated LVN 2 should have worn the proper PPE when entering an isolation room.A review of Resident 1's admission Record dated January 9, 2026, indicated the resident was admitted to the facility on [DATE], with diagnoses which included COVID-19. A review of the facility's policy and procedure titled, Infection Prevention and Control for COVID-19 Infection dated June 2023 indicated .Personal Protective Equipment .HCP (Healthcare Personnel)/Staff .all staff must wear fit tested NIOSH (National Institute Occupational Safety and Health)-approved N95 respirators in any indoor space where there are residents who are in isolation .Eye Protection .is no longer required except .when caring for resident in the COVID isolation area .According to the article published by the Centers for Disease Control and Prevention (CDC) titled, Infection Control Guidance: SARS-CoV-2 dated June 24, 2024 .Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection .Personal Protective Equipment . HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) .