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	05/27/2026

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 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 interview and record review, the facility failed to ensure a physician's order of one-to-one sitter (1:1 sitter - a person who can provide continuous observation) was consistently implemented for one of three residents, Resident 2.As a result, Resident 2 was left unsupervised which may have contributed to Resident 2 having another fall incident on May 14, 2026, where Resident 2 sustained a skin tear to his left elbow. In addition, this failure had the potential for Resident 2 to sustain major injury such as a fracture (break in the bone).Findings:A review of Resident 2's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included prostate cancer (a growth of cells that starts in the prostate, a part of the male reproductive system).A review of Resident 2's Fall Assessment dated May 12, 2026, indicated the resident was a high risk for fall.A review of Resident 2's SBAR (Situation, Background, Assessment, Recommendation - a structured communication framework) and Progress Note indicated he had fall incidents on May 12, 2026 at 4:00 a.m., on May 13, 2026 at 12:50 p.m., and on May 14, 2026 at 1:20 a.m. A review of Resident 2's Order Summary Report indicated .1:1 sitter . was ordered on May 13, 2026.On May 27, 2026, at 10:02 a.m., during a telephone interview with Certified Nurse Assistant (CNA) 2, she stated she was familiar with Resident 2. CNA 2 stated she was assigned to Resident 2 twice for the night (11-7) shift in the past. CNA 2 stated they had to watch Resident 2 every 30 minutes the last time (May 13, 2026) she was assigned to him because he had fallen in the facility more than once. CNA 2 stated there was an order for Resident 2 to have a 1:1 sitter but there was no sitter for him that night, she was told that the facility tried to get a sitter but did not get approved for one. CNA 2 stated if there was 1:1 sitter, the sitter is supposed to sit right next to the patient, some would sit outside the resident's room by the door.A record review of the facility document titled Nursing Staff Assignment and Sign-in Sheet (assignment sheet - a document that outlines which staff members are caring for which residents on a given day or shift) dated May 13, 2026 indicated CNA 2 was assigned to Resident 2. On May 27, 2026, at 10:45 a.m., during a telephone interview with Registered Nurse (RN) 1, RN 1 stated Resident 2 had fallen during her shift on the early morning hours of May 14, 2026. RN 1 stated Resident 2's medical doctor (MD) ordered a 1:1 sitter but the sitter assignment was removed due to a miscommunication between the higher ups (management), staffing concerns that having a 1:1 sitter would result in overstaffing. RN 1 stated she notified the Director of Nursing (DON) about Resident 2's fall and the DON told her that there was a plan for CNAs to alternate every 30 minutes in providing the 1:1 sitter but RN 2 did not communicate this to her. RN 1 stated Resident 2 did not have a 1:1 sitter during the night shift beginning at 11:00 p.m. on May 13, 2026.On May 27, 2026, at 11:11 a.m., during a concurrent interview with Licensed Vocational Nurse (LVN) 1 and record review of Resident 2's medical record, LVN 1 stated Resident 2 was very confused and was a fall risk, so they placed his bed in a low position and provided floor mats. LVN 1 stated the following:-Resident 2 had an unwitnessed fall on May 12, 2026, at 4:00 a.m., he was on the floor and had a red bump on the right side of his forehead. The MD and family were notified. Resident 2's vital signs were monitored, and a neurological check (repeated, quick assessments used by healthcare professionals to monitor brain (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555330	A. Building B. Wing	05/27/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and nervous system function) was initiated;-Resident 2 had an unwitnessed fall on May 13, 2026, at 12:50 p.m., a CNA found him on the floor in his room. LVN 1 stated she was the charge nurse that shift, and the CNA had just placed the resident in his wheelchair in his room, the CNA left the room and when the CNA returned, Resident 2 was on the floor. LVN 1 stated Resident 2 was moved to a room closer to the nurses' station and the RN (RN 2) got an order from the MD for a 1:1 sitter which was initiated right away; and-Resident 2 had an actual suspected fall on May 14, 2026, at 1:20 a.m., he was found on the floor mat and had a skin tear on his left elbow which treatment was provided. The MD and family were notified.On May 27, 2026, at 11:55 a.m., during a concurrent interview with the Staffing Coordinator (SC) and record review of the facility's assignment sheet for May 13, 2026, the SC stated a CNA was initially assigned to be the 1:1 sitter for Resident 2 for the night shift of May 13, 2026, but was cancelled due to overstaffing. The SC stated the facility's plan was for the CNAs to alternate every 30 minutes in providing the 1:1 sitter.On May 27, 2026, at 12:09 p.m., during a telephone interview with RN 2, she stated she obtained the order of a 1:1 sitter for Resident 2 from the MD on May 13, 2026, after he fell, and she followed up with the SC to have extra staffing. RN 2 stated Resident 2 needed a 1:1 sitter for safety because even if he is in the wheelchair or in a low bed, he was still able to get himself on the floor. RN 2 stated during the morning shift (7am-3pm) on May 14, 2026, the DON asked her to notify Resident 2's MD that a 1:1 sitter was not necessary and the order was discontinued.On May 27, 2026, at 2:53 p.m., during an interview, the DON stated Resident 2 needed a 1:1 sitter due to his fall risk. The DON stated they removed the 1:1 sitter for Resident 2 on May 14, 2026, and had CNAs alternate every 30 minutes instead. The DON stated Resident 2 should have had a sitter on the night shift of May 13, 2026, as ordered.A review of the facility's policy and procedure titled Fall Prevention Program dated December 2016, indicated .the staff, with the input of the attending physician, will identify appropriate interventions to reduce the risk of falls.A review of the facility's policy and procedure titled Safety and Supervision of Residents dated January 2018 indicated .Our individualized, resident-centered approach to safety addresses safety and accident hazards for individuals residents .The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices .Implementing intervention to reduce accident risks and hazards shall include the following .communicating specific interventions to all relevant staff; assigning responsibility for carrying out interventions .ensuring the interventions are implemented .Monitoring the effectiveness of interventions shall include the following .ensuring that interventions are implemented correctly and consistently .

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	05/27/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medical record accurately reflected care and services provided for one of three residents (Resident 1) when Resident 1's meal assistance and meal intake tasks had multiple missing entries.This failure resulted in incomplete medical records and had the potential to result in ineffective communication between staff members in monitoring Resident 1's nutritional status and response to care.Findings:A review Resident 1's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included stroke (loss of blood flow to a part of the brain) with right-sided weakness and dysphagia (difficulty swallowing).A review of Resident 1's History and Physical dated April 30, 2026, indicated the resident has the capacity to understand and make decisions.A review of Resident 1's Care Plan Report dated May 1, 2026, indicated, .The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) .cerebral infarction (stroke) with hemiplegia (weakness) right side (sic) .interventions included .EATING: The resident is totally dependent on 1 (one) staff for eating .A review of Resident 1's Documentation Survey Report for the month of May 2026, indicated the assistance for eating and nutrition-amount eaten tasks had missing entries on May 5, 6, 7, 11, 19, 2026, for breakfast and lunch; on May 8 and 9, 2026 for lunch; and on March 21, 2026 for dinner.On May 26, 2026, at 12:22 p.m., during a concurrent observation and interview, Resident 1 was in her room, lying in bed, turned to her left side, alert and awake. Resident 1 stated she was admitted to the facility due to a stroke that left her with right-sided weakness. Resident 1 stated she needs assistance to eat.On May 26, 2026, at 1:16 p.m., during a concurrent interview with Certified Nurse Assistant (CNA 1) and a record review of Resident 1's medical record, CNA 1 stated she assisted Resident 1 all the time with eating. CNA 1 stated Resident 1 ate 60 % of her meals and she documented it in the electronic charting. CNA 1 confirmed she was assigned to Resident 1 on May 7, 2026, for the 7-3 (morning) shift. When asked to explain why there were no entries for breakfast and lunch on May 7, 2026, CNA 1 stated it was because the computer was not working and the facility did not have any Wi-Fi (a wireless networking technology that enables electronic devices to connect seamlessly to a network) for three days.On May 26, 2026, at 3:08 p.m., during an interview with the Director of Staff Development (DSD) and record review of Resident 1's medical record, the DSD stated CNAs document on the POC (Point of Care - an electronic charting tool) ADL Task how the resident was assisted with eating and how much they consumed for meals, and these should be documented daily for breakfast, lunch, and dinner. The DSD stated the ADL Tasks for assistance in eating and nutrition-amount eaten had incomplete documentation for the month of May 2026. The DSD stated there is no evidence that Resident 1 ate meals on multiple dates. The DSD stated the CNAs should document daily and accurately complete their charting.On May 27, 2026, at 2:53 p.m., during an interview with the Director of Nursing (DON), the DON stated anything that is not documented is not done. The DON stated for Resident 1, how would they know if the resident was eating when there is no documentation.A review of the facility's policy and procedure titled, Charting and Documentation dated January 2018 indicated .All services provided to the resident .shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary [NAME] regarding the resident's condition and response to care .