STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555365	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Terrace Care Center	11162 Palm Terrace Lane Riverside, CA 92505

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interview, and record review, the facility failed to ensure an allegation of abuse was reported to the facility abuse coordinator timely according to the facility's policy and procedure, for one of three residents reviewed (Resident A).This failure had a potential for a delay in the implementation of the abuse protocol of investigation and protecting the residents from further abuse. Findings:On March 3, 2026, at 10:25 a.m., an unannounced visit was conducted at the facility to investigate a complaint and facility reported incident regarding resident abuse.On March 3, 2026, at 10:30 a.m., during an interview with the Director of Nursing (DON), the DON stated a therapy student (TS) reported to Adult Protective Services (agency) that a Certified Nursing Assistant (CNA) handled a resident in a manner that was not acceptable to the rehab student. The DON stated Resident A had a change of condition when the resident was combative to staff.On March 3, 2026, at 11:30 a.m., an interview with the CNA was conducted. The CNA stated she provided care to Resident A when he came back from the hospital and was being combative during care. The CNA stated Resident A was rubbing his mouth hard with a wash cloth and the side of the resident's mouth bled as it was dry. The CNA stated she reported the bleeding on Resident A's mouth to the licensed nurse. The CNA stated the TS came in to assist the CNA so the TS could start Resident A's therapy. The CNA stated she changed Resident A's shirt and socks before the TS worked with the resident, then she left the room. The CNA stated at around 10 a.m., the Director of Staff Development (DSD) came to inform her that Resident A would be removed from her run as there was a complaint against her. The CNA stated she was counseled by the DON but was not suspended.On March 3, 2026, at 12 p.m., the Director of Rehabilitation (DOR) was interviewed. The DOR stated the TS informed him in the morning of February 18, 2026, that he had reported to APS a concern on abuse toward Resident A by the CNA. The DOR stated he went to the TS clinical instructor and both of them went to the Administrator (Admin) and informed about the abuse allegation.On March 3, 2026, at 12:30 p.m., the TS was interviewed. The TS stated that when he began the therapy of Resident A, the resident kept repeating a mean lady hit him. The TS stated that he worked with Resident A on February 16, 2026 (Monday), and the resident was combative as the resident would not let him put on his socks, he had a lot of food on his shirt, and the clinical instructor wiped the resident's mouth and there was no blood. The TS stated when he and the rehab clinical instructor came back to Resident A's room after about 45 minutes, he heard Resident A yelling No, and the CNA said to the resident, we are not doing this today, and she pulled the resident's sheet and the resident hit the bed railing. The TS stated the CNA was angry at Resident A and was yelling at the resident while putting socks and a new shirt on. The TS stated he informed the Physical Therapy Lead (PTL) and his clinical supervisor on February 17, 2026, then he reported the abuse allegation to APS the night of February 17, 2026. On March 3, 2026, at 1:45 p.m., during a follow up interview with the DOR, the DOR stated he informed the Admin the morning of February 18, 2026, when he found out from the TS that he had filed a report to APS regarding the abuse allegation. The DOR stated the rehab students were educated on to report abuse allegations to their clinical instructor or to the DOR then the DOR would inform the Admin to ensure investigation was initiated. The DOR stated the TS did not follow the chain of command for reporting abuse allegations.On March 3, 2026, at 2:55 p.m., during an interview with the Admin, the Admin stated he (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received a call from the DOR the morning of February 18, 2026, about an abuse allegation reported by the TS against a CNA toward Resident A. The Admin stated the TS should have reported the abuse allegation to his clinical instructor, then to reported to the Admin to ensure the abuse protocol could be followed.On March 4, 2026, at 8:30 a.m., during an interview with the PTL, the PTL stated the TS came to him either February 16 or 17, 2026, regarding a concern he had on the alleged CAN, and that the TS was upset. The PTL stated he did not ask the TS further what the concern was and he reported it to the DOR. The PTL stated the DOR told him that the DOR would talk to the TS clinical instructor.A review of the facility's policy and procedure titled, Reporting Alleged Violations of Abuse, neglect, Exploitation or Mistreatment, dated April 2025, indicated, .Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment.are reported to immediately.The Administrator of the Facility.Ensure that, after receipt of a report of possible abuse.steps are immediately taken to protect the identified resident.