STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555404	A. Building B. Wing	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Village Healthcare Center	17040 Arnold Dr. Riverside, CA 92518

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** 46145 Based on observation, interview and record review, the facility failed to Establish and maintain safe resident smoking practices, per the facility's Policy & Procedure (P&P) Smoking Policy-Resident, as two residents (Residents1&2) were observed smoking on the patio, without staff supervision. This failure could have resulted in injuries to Residents1&2, while smoking without staff supervision. Findings: On October 27, 2023, at 11:15 a.m., an unannounced revisit was conducted at the facility for a Quality-of-Care issue. On October 27, 2023, an interview was conducted with the Director of Nursing (DON), who indicated, Smoking Patio hours are at designated times. Residents can go out on patio at anytime but must be monitored by staff when smoking. DON further stated, the activities staff are responsible to hand out the smoking paraphenalia (Cigarettes & lighters), and monitor the smoke breaks, then staff collect the cigarettes and lighters until the next smoke break. On October 27, 2023, at 11:45 a.m., a concurrent observation of the smoking patio, and interview with the DON was conducted. A sign on the smoking patio indicated the daily smoke breaktimes. The next smoke break time was observed to be .12:00 - 12:10 (p.m.) . Outside on the smoking patio, 2 residents (Resident1&2) were observed smoking, unsupervised by staff. Resident 1 was observed in possession of 1 cigarette box and 1 lighter. DON verified, residents Shouldn't be on the patio smoking without being monitored by staff. DON stated, Staff should be out here watching them (Smoke), and (Residents) shouldn't have their cigareetes and lighters without staff. On October 27, 2023, at 12:06 p.m., a concurrent interview with the Acitivity Assistant (AA), and observation of smoking patio was conducted. Residents 1&2 were observed smoking on the patio being monitored by AA. AA stated she had been employeed at the facility for One week, and she is responsible to take residents out to smoke during smoke breaks, monitor residents smoking, then collect their lighter and cigarettes. Residents are to come to her to get their lighter and cigarettes and she will take then out to smoke. AA verified, she did not know Resident1 had his cigarettes and lighter in his possession, or how he got them prior to smoke break. AA stated, I collected them (Resident1's light and cigarettes). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555404	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/09/2023
NAME OF PROVIDER OR SUPPLIER: Riverside Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 17040 Arnold Dr. Riverside, CA 92518	

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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	On October 27, 2023, a review of Resident1's medical records was conducted. Residents Face sheet, indicated he was admitted to the facility on [DATE], with a diagnosis of Chronic Obstructive Pulmonary Disease (A disease that causes contriction of the airway and difficulty breathing) and Asthma (Spasms in the lungs, causing difficulty breathing). Resident1's BIMS (Brief Interview of Mental Status - a test of mental cognition) score was 15, indicating cognitive intactness. Resident1's Smoking Safety Screen, dated August 24, 2023, indicated, resident .May smoke with supervision . requiring, .Adaptive equipment (of) 1. Smoking Apron . Review of Resident1's Care Plans indicated; no care plan was developed for smoking. On October 27, 2023, at 2:10 p.m., an interview was conducted with Resident1. Resident1 verified he was smoking on the patio, unsupervised earlier in the day (at 11:45 a.m.). Resident1 stated, staff Usually, monitor smoking breaks on the patio, and collect his cigarettes and lighter, when smoking break is over, but Sometimes (staff) forget (to collect cigarettes and lighter). Resident1 further stated, he Couldn't remember, how he had his cigarettes and lighter with him, during his unsupervised smoking break. Resident1 further verified, staff do ask him to wear a smoking apron when he goes out to smoke, and he refuses to wear it, stating, I don't like it, It's too hot and heavy, and I don't need. On October 27, 2023, a review of Resident2's medical records was conducted. Resident2's Face Sheet, indicated, he was admitted to the facility on [DATE], with a diagnosis of traumatic brain injury and right-sided hemiplegia (paralysis of one side of the body), with a BIMS score was 01, indicating severe cognitive impairments. Resident2's Smoking Safety Screen, dated July 7, 2023, indicated, . Resident is a smoker . requiring .Supervision . while smoking. Review of Resident2's Care Plans, indicated, resident did have a care plan developed for smoking, stating, .(Resident2) is a smoker . requires SUPERVISION while smoking . On November 7, 2023, at 10:53 a.m., an interview was conducted with the Activity Director (AD). AD stated activity staff are responsible for taking the residents out and monitoring them during the designated smoke breaks. AD and her assistant (AA) will go out to the smoking patio and monitor smoking residents for the duration of the smoke break. The nursing staff will assess new residents for Smoking safety, during the admission process, and she will print a copy of the residents smoking safety assessment, and put it in the Smoking binder, so special needs of the smoking residents are easily accessed. If is a resident is assessed for the need of a smoking apron for safety, then the apron is handed to the resident during the smoking break. AD further stated, she will orient new residents to the facility's Smoking policy and safety rules, which includes smoking requirements and use of smoking aprons, then resident will sign (a copy of documents reviewed). AD verified, she does not have a copy of Resident1&2's Smoking safety, documents, as Both residents discharged , and I threw the documents away. AD further stated, Resident1 Often refused (to wear) the smoking aprons, and she notifies nursing staff, if a resident repeatedly refused to wear their smoking apron, but she could not Remember, if nursing staff was notified of Resident1 refusing to wear the smoking aprons. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Village Healthcare Center	17040 Arnold Dr. Riverside, CA 92518

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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	On November 7, 2023, at 1:15 p.m., an interview was conducted with the DON. The DON verified Resident 1 was a smoker, and a Smoking, care plan was missing from the resident's medical records. DON stated, a smoking care plan for Resident 1, should have been developed within 14 days of admission on August 24, 2023, after being identified as a smoker. DON further verified, Resident1 was not wearing a smoking apron, and should have been, when observed smoking on the patio, unmonitored by staff, on October 27, 2023, at 11:45 a.m. DON stated, if a resident refuses to wear a smoking apron, then the resident can smoke if monitored by staff, then the resident should then be re-assessed by nursing staff, for smoking safety without an Apron, and the care plan should also be updated. DON verified Resident 1 was not re-assessed for Smoking safety, after refusing to wear a smoking apron. A facility Policy & Procedure, titled, SMOKING POLICY-RESIDENT, updated, 3/06/2023, indicated, .This facility shall establish and maintain safe resident smoking practices . d. Ability to smoke safely with or without supervision (per a completed Smoking Safety Screen) . 8. A resident's ability to smoke safely will be re-evaluated . as determined by staff . 11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervison of a staff member, family member, visitor or volunteer worker at all times while smoking . 12. Residents with or without independent smoking privileges are not permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession including lighters or matches.

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NAME OF PROVIDER OR SUPPLIER Riverside Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 17040 Arnold Dr. Riverside, CA 92518	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46145 Based on observation, interview and record review, the facility failed to ensure Resident 1 was free from significant medication errors on October 27, 2023, as Licensed Vocational Nurse 1 (LVN1) did not follow the facility's Policy & Procedure (P&P), Administering Medications, as she left Resident 1's medications in his hand, and exited resident's room, before witnessing Resident 1 take his medications. This failure resulted in Resident 1 missing his 8:00 a.m. dose of medications, including Metocarbonal and Cyclobenzaprine (Muscle relaxers, used to relieve muscle spasms). Findings: On October 27, 2023, at 11:15 a.m., an unannounced Quality-of-Care issue was conducted. During an observation on October 27, 2023, at 11:55 a.m., of Resident 1 in his bedroom, resident was observed lying flat in bed, reaching to the right of his bed, for 2 orange-colored pills on his bedside table; An empty medication cup and several pills were observed on Resident 1's mattress next to him, and one pill observed on resident's shoulder. Resident 1 was further observed moving his mouth, making inaudible noises, as he was reaching for the pills on his bedside table, unresponsive to questions regarding his medications. On October 27, 2023, at 12:10 p.m., a concurrent observation and interview with LVN 1, at Resident 1's bedside, LVN 1 stated she is the nurse responsible for administering Resident 1's daytime medications. LVN 1 observed Resident 1 lying in bed, and stated, Oh no, you didn't take your pills. Resident 1 did not verbally respond, he was observed mouthing inaudible words and reaching for his bedside table with medications on it. LVN 1 was observed picking medications off Resident 1's mattress, his gown (shoulder) and bedside table. LVN 1 began to review the medications she was picking up, with Resident 1, stating, This is your flexeril (Muscle relaxer), your metocarbonal (Muscle relaxer), your calcium (Mineral supplement). Resident 1 did not respond verbally. Observed LVN 1 pick up 8 pills and place in the medication cup that was on the bedside table. On October 27, 2023, at 12:15 p.m. an interview with LVN1 was conducted. LVN1 stated, The (Facility's medication administration) policy is, We always have to make sure patients swallow their pills before we leave the room. LVN1 verified, I left (Resident1's) pills in a medication cup, in his hand, and did not wait for him to swallow them, and I did not come back to make sure (Resident1) took all of (his medications). LVN1 further verified, Resident 1 does not have doctor's (Dr's) to self-administer his own medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's October 27, 2023, MAR, and concurrent interview with LVN 1 was conducted. LVN 1 reviewed Resident 1's MAR, against the 8 pills recovered from his room, stating, Oh some of these (Medications) are from this morning (8:00 & 9:00 a.m. dose). LVN 1 verified, Residen t1 did not receive his 8:00 a.m. dose of Ferrous Sulfate (Iron supplement), 9:00 a.m. doses of Cyclobenzaprine (Muscle relaxer) 5 mg (Milligrams, a unit of measure), Methocarbonal (Muscle relaxer) 500mg, Colace 100 mg, and Calcium (mineral supplement) 500mg, and 12:00 p.m. doses of Metocarbonal 500 mg, Colace 100 mg and Calcium 500mg. Further review of Resident1's MAR, dated, October 27, 2023, indicated, all of Resident1's 8:00 & 9:00 a.m. medications were initialed by LVN1, indicating the medications were administered by LVN1, and taken by Resident1. Review of Resident1's admission medical records was conducted. Resident1's face sheet, indicated, resident was admitted to the facility May 7, 2020, with a diagnosis of lower leg muscle contracture (When muscles tighten or shorten causing pain, loss of movement to joints, and deformity). Resident1's Brief Interview for Mental Status (BIMS) score was 12 (Moderate cognitive impairment). Review of Resident1 Dr's orders, verified, resident has no orders to self-administer his medications. Further review indicated, Resident 1 has the following medication orders: Cyclobenzaprine 5 mg tablet, three times per day (9:00 a.m., 1:00 & 5:00 p.m.); Methocarbamol 500 mg tablet, three times per day (9:00 a.m., 1:00 & 9:00 p.m.); Ferrous Sulfate, 65 mg tablet, with meals, (8:00 a.m., 12:00 & 5:00 p.m.); Calcium 500-200 tablet, two times per day, (9:00 a.m. & 5:00 p.m.); Senokot (Colace) 8.6-50 mg, two times per day (9:00 a.m. & 5:00 p.m.). On October 27, 2023, at 1:01 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, The facility's procedure for passing medications is to stand with the resident until the medications are swallowed, and verify the medications are taken before (the nurse) leaves the room. The DON verified, (LVN1) did not follow proper facility procedure by Not waiting to see if (Resident1) took his medications before leaving (Resident1's) room. The DON further verified, a resident must be assessed by the Interdisciplinary Team (IDT), and the doctor for the cognitive ability to self-administer their medications, and Resident1 has not been assessed by the IDT or doctor to self-administer his medications. During a review of the facility's policy and procedure titled, Admistering Medications, revised December 2012, indicated, .Medications shall be administered in a safe and timely manner, and as prescribed . 4. Medications must be administered in accordance with the orders . 24. Residents may self-administer their own medications only if the Attending Physician, in conjuction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely .