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	07/23/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46509 Based on interview and record review, the facility failed to ensure two (Resident A and Resident B) of three sampled residents was assessed properly for bladder and bowel continence. This failure resulted in Resident A and Resident B not being identified, assessed and provided appropriate treatment and services to improve or restore as much bladder and bowel function as possible. Findings: On July 5, 2024, at 12:30 p.m., an unannounced visit to the facility was conducted to investigate a complaint for quality of care. 1. On July 5, 2024, a review of Resident A's medical record indicated Resident A was admitted to the facility on [DATE], with diagnoses which included intracerebral hemorrhage (bleeding inside the brain) and epileptic syndrome (a group of symptoms causing seizures). Resident A's Minimum Data Set (MDS - a resident assessment tool), dated June 2, 2024, indicated Resident A was always continent (ability to control) for urinary and bowel function continence. Resident A's Documentation Survey Report, dated June 2024, indicated Resident a had episodes of bladder incontinence and was placed on adult brief from June 2 to 7, 2024. Resident A's eINTERACT Transfer Form, dated June 8, 2024, at 1:05 p.m., indicated .bladder function: incontinent . Further review of Resident A's medical record indicated there was no documented evidence an assessment was initiated when there was a change in bladder function from being continent to episodes of incontinence. There was no documented evidence a plan of care was developed to address bladder incontinence. On July 8, 2024, at 1:10 p.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated Resident A was incontinent in bladder. On July 8, 2024, t 1:30 p.m., CNA 2 was interviewed. CNA 2 stated Resident A was mostly incontinent and wore an adult brief. (continued on next page)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On July 8, 2024, at 1:50 p.m., a concurrent interview and record review was conducted with the MDS coordinator. The MDS Coordinator stated residents were to be monitored for bowel and bladder function for three days upon admission. He stated he would then appropriate bladder and bowel program were to be developed for the resident's bladder and bowel function review. He stated the bladder and bowel program would be re-evaluated after 14 days. The MDS stated Resident A was continent of bladder and bowel and went to the restroom and did not need bowel or bladder program upon admission. The MDS stated Resident A had bladder incontinence episodes in June, and a change of condition should have been initiated and be assessed for another three days and place Resident A in a bladder program. He stated a plan of care to address periods of incontinence should have been developed to address periods of incontinence to regain continent bladder function 2. On July 5, 2024, at 3:45 p.m., an interview was conducted with Resident B. Resident B stated she was incontinent of bladder and bowel and wears a brief at all times. Resident B stated she does not get out of bed to use the toilet; her brief was being changed when she is soiled. On July 5, 2024, a review of Resident B's medical record indicated Resident B was admitted to the facility on [DATE], with diagnoses which included cystitis (infection of the lower urinary tract and the bladder) and sepsis (infection in the blood). Resident B's Order Summary Report, dated May 31, 2024, indicated to check and change brief every two hours x 14 days, then re-evaluate. Resident B's MDS, dated [DATE], Resident B was frequently incontinent with bowel and bladder. Resident B's Daily Skilled Documentation, dated June 30 2024 and July 1 through July 4, 2024, indicated .pt (patient) incontinent of bowel and bladder . There was no documented evidence a care plan to address bowel and bladder incontinence for Resident B. On July 8, 2024, at 1:50 p.m., a concurrent interview and record review was conducted with the MDS coordinator. The MDS Coordinator stated Resident B should have been placed on a bowel and bladder program for 14 days following her 4th day of incontinence, the nurses should have developed a care plan with interventions to support Resident B. The MDS stated no care plan was initiated, and no interventions were put in place to help Resident B re-gain some bowel and bladder control. A review of the facility's policy titled Change in a Resident's Condition or Status, dated May 2017, indicated, . A 'significant change' of condition requires interdisciplinary review and/or revision to the care plan .the nurse will make detailed observations and gather relevant and pertinent information for the .SBAR Communication Form .if a significant change in the resident's physical condition occurs, a comprehensive assessment of the resident's condition will be conducted .any noted changes will be reported to the director of nursing services to ensure information is changed in the resident's medical record . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Bowel and Bladder Protocol, dated April 5, 2022, indicated, .to improve and/or restore the resident's bowel and bladder function to the extent possible and prevent possible urinary tract infections .Residents who exhibit an improvement or decline in bowel and bladder function will be assessed .upon resident's admission to the facility, start 72-hour bowel and bladder observation .CNA will document in the 72-hour bowel and bladder observation diary .Licensed Nurses will collect and review the data from the 72-hour bowel and bladder observation diary and complete the Bowel and Bladder Program Screen-V2 Form . based on the . score, the licensed nurse or IDT (interdisciplinary team) will determine resident's ability to participate in .bowel and bladder incontinence behavior program . A review of the facility's in-service training record, dated December 29, 2023, indicated .Topic of Inservice COC (change in condition) documentation .include a progress note at the beginning of your shift when documenting COC's .