

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  03/10/2026
NAME OF PROVIDER OR SUPPLIER  Riverside Village Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure behavioral health care and services were provided, for one of three residents reviewed (Resident A), when the resident was not provided psychiatric/psychological consult when the resident continues to exhibit behaviors of refusal of care and medications. This failure resulted in Resident A's behavior of continued refusal of meals, medications, and activities of daily living (bathing, toileting, and continence [bladder and bowel function]) care needs, and being sent to the hospital for a further evaluation. Findings: On February 4, 2026, at 11 a.m., an unannounced visit to the facility was conducted for an investigation of complaints regarding quality of care and treatment. On February 4, 2026, at 11:10 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident A was only in the facility for a few weeks and the resident had a history of schizophrenia (severe brain disorder characterized by delusions, hallucinations, disorganized thoughts and speech). The DON stated Resident A was refusing to eat and would tell others that the facility was not feeding her. The DON stated the facility called Resident A's family member to inform them of the resident's behavior and confirmed they were aware of the resident's behaviors and that Resident A had called the police and had come out to evaluate her. On February 4, 2026, a review of Resident A's medical record was conducted. Resident A was admitted to the facility on [DATE], with diagnoses which included schizoaffective disorder (mental health condition combining schizophrenia symptoms with mood disorder episodes) and depression. A review of Resident A's admission H &amp; P [History and Physical], documented by the physician, dated December 18, 2025, indicated, .Has decision making capacity. A review of Resident A's Minimum Data Set (MDS - a resident assessment tool), dated December 23, 2025, indicated a BIMS (Brief Interview for Mental Status) score of 14 (cognitively intact). A review of Resident A's Order Summary Report, included physician's orders which included the following psychotropic medications:-Aripiprazole Oral Tablet 10 mg one tablet one time a day for schizoaffective disorder M/B delusional thoughts; date ordered December 19, 2025; and-Lexapro (medication used to treat depression) 10 mg (milligram - unit of measurement), one (1) tablet one time a day for Depression M/B (manifested by) self-report of feeling depressed; date ordered December 22, 2025; A review of Resident A's Medication Administration Record (MAR), for the month of January 2026, indicated Resident A began to refuse her medications on the following dates:- January 1, 2026, Lidocaine Patches (numbing medication for pain).- January 2, 2026, Atorvastatin Calcium (cholesterol medication) and Gabapentin (used to treat nerve pain).- January 4, 2026,; Lexapro, Aripiprazole, Benazepril (also called Lotensin - used to treat high blood pressure, heart failure, and kidney disease), Celebrex (helps reduce pain, swelling, stiffness), Colace (stool softener for constipation), Vitamin C, Multi-vitamin, and Zinc supplement.- January 5, 2026, Protonix (also called pantoprazole-used to treat gastric acid in the stomach).- January 6, 2026, began to refuse having her with blood sugar checked. On January 5, 2026, Resident A began to exhibit episodes of schizoaffective disorder with delusional thoughts, and the frequency of episodes increased and continued until being sent out to the hospital on January 10, 2026. A review of Resident A's Change of (continued on next page)</p>

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
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CNA 1 stated she took care of Resident A while at the facility. Resident A did not like the food and accused the facility of starving her and not giving her any food. CNA 1 stated Resident A refused several of her meals, would be demanding and confused at times, would refuse to be showered, and would affect her personal hygiene.On February 4, 2026, at 1:50 p.m., an interview was conducted with CNA 2. CNA 2 stated Resident A would refuse her showers, and she would ask her several times throughout the day. CNA 2 stated on the morning of January 10, 2026, she gave the Resident A her breakfast, opened all the items on her meal tray and she ate the sausage and drank the coffee but refused to eat anything else, she refused her lunch tray completely, and there were orders in place, if the resident continued to refuse her meals they were to send Resident A to the hospital. CNA 2 stated a few days before transferring Resident A to the hospital, the resident had refused to have her diaper changed or be put to bed on the evening shift, she sat in her wheelchair in front of the nurse's station and refused to move. CNA 2 stated we would offer Resident A bed bath, she would refuse, at one point she smelled, and we begged her to shower and she still refused. On February 4, 2026, at 4 p.m., conducted an interview with the DON. The DON stated there was a psychiatric consult ordered for Resident A on January 6, 2026, and it was to be completed the following day, but the psychiatrist needed to postpone his visit until January 15, 2026, and this delayed her needed evaluation and was she sent to the hospital on January 10, 2026 for refusing food, medications, and basic care. The DON stated referral for psychiatry should have been initiated immediately and if not able to be coordinated due to availability, the primary MD should have been informed for further orders to manage her behavior.A review of the facility's policy titled Change in a Resident's Condition or Status, dated May 2017, indicated, .significant change in the resident's physical/emotional/mental condition.refusal of treatment or medications.impacts more than one area of the resident's health status.a comprehensive assessment of the resident's condition will be conducted as required.A review of the facility's policy titled Behavioral Health Services, dated February 2019, indicated, (continued on next page)</p>		

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