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 05/09/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45555 Based on interview, record review, and facility policy review, the facility failed to provide advance directive information to 1 (Resident #57) of 5 residents reviewed for advance directives. Findings included: A facility policy titled, Advance Directives, revised in 12/2016, indicated, Advance Directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 2. Written information will include a description of the facility's policies to implement advance directives and applicable state law. An Admission Record revealed the facility admitted Resident #57 on 04/20/2024. Resident #57's Physician Orders for Life-Sustaining Treatment (POLST), prepared on 04/20/2024, revealed the section addressing advance directives was not completed. Resident #57's Consents form, dated 04/20/2024, revealed the Advance Directives section was incomplete. This section of the form was not signed to indicate the facility had offered the resident information about advance directives or the facility's policy on advance directives and did not indicate if the resident had executed an advance directive. During an interview on 05/07/2024 at 12:11 PM, the Director of Nursing (DON) stated she was not able to locate an advance directive, acknowledgement, or documentation of discussions regarding advance directives with Resident #57. The DON stated the process of determining whether the resident had an advance directive and providing information on advance directives should have started at the time of the resident's admission to the facility. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2024 at 2:44 PM, the Social Services Director (SSD) stated residents were asked during their care conference if they had an advance directive or if they would like information about advance directives. She stated this discussion was documented in a care conference note; however, the SSD said she was on vacation when Resident #57 was admitted , so the Social Services Assistant (SSA) participated in the care conference meeting. The SSD reviewed Resident #57's care conference meeting notes and stated that a discussion about advance directives was not documented, but it should have been. During an interview on 05/09/2024 at 8:00 AM, the DON stated social services should provide information to residents regarding advance directives. She stated she was not sure why Resident #57 was not provided advance directive information. During an interview on 05/09/2024 at 8:20 AM, the Administrator stated that usually social services discussed advance directives with the residents during the care conference and documented the conversation in the care conference note. During an interview on 05/09/2024 at 8:52 AM, the SSA stated she helped the SSD, and they both offered advance directives to residents. The SSA said if a resident wanted to execute an advance directive, they reached out to the Ombudsman to come in and complete the form. She stated she documented conversations about advance directives in the care conference notes but stated recently they had not been documenting it, but she did not know why. She stated she did remember the care conference with Resident #57 but could not say if advance directives were discussed.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 28196 Based on observation, interview, and facility policy review, the facility failed to ensure privacy was provided during resident care for 1 (Resident #46) 1 resident reviewed for privacy. Findings included: A facility policy titled, Dignity, revised in 02/2021, indicated, 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. An Admission Record revealed the facility admitted Resident #46 on 02/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of quadriplegia and muscle wasting and atrophy. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/04/2024, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had a functional limitation in range of motion on both sides of their upper and lower extremities, was dependent on staff for toileting hygiene, and was always incontinent of urine and bowel. Resident #46's comprehensive care plan revealed a Focus area, initiated on 03/01/2024, that indicated the resident demonstrated decreased strength and balance for safe bed mobility, transfers, and gait. Another Focus area, initiated on 03/01/2024, indicated the resident was at risk for skin breakdown and included an intervention dated 03/01/2024 that directed staff to assist with toileting needs if needed. During an observation on 05/06/2024 beginning at 12:01 PM, Certified Nurse Assistant (CNA) #4 and CNA #3 transferred Resident #46 from a geriatric chair to their bed using a mechanical lift. There was no privacy curtain in the room, the window blinds were open, and Resident #46's roommate was seated on their bed watching the transfer. At 12:13 PM, after Resident #46 asked to be changed because of an incontinent episode, CNA #4 gathered the necessary supplies, pulled Resident #46's gown up to the top of their brief, and unfastened both sides of the resident's brief while their roommate was watching. After initiating incontinence care, CNA #4 informed the resident they would need to wait to finish the care until their privacy curtain was hung back up, so that they could have privacy during the care. During an interview on 05/07/2024 at 2:59 PM, CNA #4 stated staff pulled the privacy curtain completely around the resident during resident care to ensure privacy but said they did not do that on 05/06/2024, because Resident #46's privacy curtain was removed from their room for cleaning. During an interview on 05/08/2024 at 10:03 AM, CNA #3 stated staff pulled the privacy curtain and closed the blinds during resident care. CNA #3 stated Resident #46's privacy curtains were in laundry being cleaned. She indicated they should not have transferred the resident to their bed for care until they could provide the resident with privacy. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2024 at 11:11 AM, the Director of Nursing (DON) said she expected residents to be provided privacy during a mechanical lift transfer. She also said the aides should have come to one of the administrative staff to intervene and should not have proceeded until they could ensure the resident's privacy during care. During an interview on 05/09/2024 at 8:25 AM, the Administrator stated that he expected staff to provide residents with privacy during any resident care tasks.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31524 Based on interview, record review, and facility document and policy review, the facility failed to accurately code Minimum Data Set (MDS) assessments for 4 (Residents #34, #61, #16, and #30) of 17 residents reviewed for MDS accuracy. Findings included: A facility policy titled, Certifying Accuracy of the Resident Assessment, revised in 11/2019, indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The policy further indicated, 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. 1. An Admission Record revealed the facility admitted Resident #34 on 05/03/2023. According to the Admission Record, the resident had a medical history that included diagnoses of idiopathic peripheral autonomic neuropathy (disorder of the nerves that regulate body processes), Alzheimer's disease, and dysphagia (swallowing disorder). Resident #34's Order Summary Report, listing active orders as of 05/07/2024, revealed an order, dated 12/30/2023, to admit Resident #34 to hospice on 12/30/2023 with a diagnosis of senile degeneration of the brain. Resident #34's Hospice Plan of Care, certified from 12/29/2023 through 03/27/3034, indicated hospice services started on 12/29/2023. Resident #34's quarterly MDS, with an Assessment Reference Date (ARD) of 03/19/2024, revealed Resident #34 had a Brief Interview for Mental Status (BIMS) score of 1, indicating the resident had severe cognitive impairment. However, the MDS did not reflect the resident received hospice care while a resident of the facility or within the 14 days prior to the assessment. During an interview on 05/08/2024 at 1:53 PM, the MDS Coordinator acknowledged Resident #34's quarterly MDS dated [DATE] was not accurate and should have been coded to reflect the resident received hospice services while a resident of the facility. During an interview on 05/09/2024 at 8:00 AM, the Director of Nursing (DON) stated Resident #34's quarterly MDS dated [DATE] should have reflected the resident received hospice services while a resident of the facility. During an interview on 05/09/2024 at 8:20 AM, the Administrator stated he expected a resident's MDS to accurately reflect if they were receiving hospice services while a resident of the facility. 28196 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. An Admission Record revealed the facility admitted Resident #61 on 12/28/2023. According to the Admission Record, the facility discharged the resident on 03/02/2024 to a Board and care/assisted living/group home. Resident #61's Order Summary Report, listing active orders as of 03/08/2024, revealed an order dated 02/28/2024 that directed staff to discharge the resident to an assisted living facility on 03/02/2024. Resident #61's Progress Notes revealed the following entries: - a note dated 02/29/2024 at 10:23 AM that indicated the resident was going to be discharged to an assisted living facility in two days; and - a note dated 03/02/2024 at 12:06 PM, that indicated the resident was discharged home via private transportation. Resident #61's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/02/2024, indicated Resident #61 was discharged to a Short-Term General Hospital, instead of Home/Community. Per the MDS, Home/Community was the appropriate discharge status for residents who were discharged to a private home or apartment, assisted living facility, group home, or other residential care arrangement. During an interview on 05/08/2024 at 2:10 PM, the MDS Coordinator stated Resident #61's discharge MDS was coded to reflect the resident was discharged to a hospital but should have been coded to reflect the resident was discharged home. During an interview on 05/09/2024 at 7:59 AM, the Director of Nursing (DON) confirmed Resident #61's discharge assessment was inaccurate, because the MDS should have reflected the resident was discharged home, not to a hospital. During an interview on 05/09/2024 at 8:20 AM, the Administrator stated if a resident was discharged home, their MDS should be coded to reflect they were discharged home, not to a hospital. 45555 3. An Admission Record indicated the facility admitted Resident #16 on 03/09/2024. Resident #16's Physician Orders for Life-Sustaining Treatment (POLST), prepared on 03/09/2024, revealed in the event the resident was found with no pulse and not breathing, the resident elected Do Not Attempt Resuscitation/DNR (Allow Natural Death). The POLST reflected this information was discussed with the resident, and the resident had No Advance Directive; however, the section of the form for the physician, nurse practitioner, or physician assistant signature was not signed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/15/2024, revealed the MDS reflected that Resident #16 had a POLST form in their chart that was signed by a physician, nurse practitioner, or physician assistant. The MDS further indicated that the section of the POLST addressing advance directives was discussed with the resident's legally recognized decision maker and was not completed, as opposed to reflecting the resident did not have an advance directive as indicated on their POLST. During an interview on 05/08/2024 at 1:44 PM, the MDS Coordinator reviewed Resident #16's MDS and POLST and confirmed the resident's MDS was not accurate. The MDS Coordinator said the resident's POLST was not signed by a physician, nurse practitioner, or physician assistant, so he should not have coded the MDS to reflect that it was signed. The MDS Coordinator further stated the section of the MDS related to advance directives was not accurate. During an interview on 05/09/2024 at 8:00 AM, the Director of Nursing (DON) stated she expected the information on the MDS to be accurate. The DON stated the MDS should accurately reflect POLST information and confirmed that Resident #16's MDS was not accurate. During an interview on 05/09/2024 at 8:20 AM, the Administrator stated he expected the MDS to be accurate. The Administrator stated the MDS should accurately reflect POLST information and confirmed that Resident #16's MDS was not accurate. 4. An Admission Record indicated the facility admitted Resident #30 on 01/11/2022. Resident #30's Physician Orders for Life-Sustaining Treatment (POLST), prepared on 01/31/2024, revealed in the event the resident was found with no pulse and not breathing, the resident elected Attempt Resuscitation. The POLST reflected this information was discussed with the resident, and the resident had an advance directive dated 01/30/2024; however, the section of the form for the physician, nurse practitioner, or physician assistant signature was not signed. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/03/2024, revealed the MDS reflected that Resident #30 had a POLST form in their chart that was signed by a physician, nurse practitioner, or physician assistant. The MDS further indicated that the section of the POLST addressing advance directives was discussed with the resident and was not completed, as opposed to reflecting the resident did have an advance directive as indicated on their POLST. During an interview on 05/08/2024 at 1:44 PM, the MDS Coordinator reviewed Resident #30's MDS and POLST and confirmed the resident's MDS was not accurate. The MDS Coordinator said the resident's POLST was not signed by a physician, nurse practitioner, or physician assistant, so he should not have coded the MDS to reflect that it was signed. The MDS Coordinator further stated the section of the MDS related to advance directives was not accurate. During an interview on 05/09/2024 at 8:00 AM, the Director of Nursing (DON) stated she expected the information on the MDS to be accurate. The DON stated the MDS should accurately reflect POLST information and confirmed that Resident #30's MDS was not accurate. During an interview on 05/09/2024 at 8:20 AM, the Administrator stated he expected the MDS to be accurate. The Administrator stated the MDS should accurately reflect POLST information and confirmed that Resident #30's MDS was not accurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45555 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a care plan was developed to address smoking for 1 (Resident #32) of 1 sampled resident reviewed for smoking and failed to ensure the care plan reflected the level of assistance required with activities of daily living (ADLs) for 1 (Resident #46) of 2 sampled residents reviewed for ADLs. Findings included: An undated facility policy titled, Goals and Objectives, Care Plans, indicated, 3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: a. Are resident oriented; b. Are behaviorally stated; c. Are measurable; and d. Contain timetables to meet the resident's needs in accordance with the comprehensive assessment. 4. Goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. 1. An Admission Record indicated the facility admitted Resident #32 on 04/22/2024. Resident #32's Smoking-Safety Screen, dated 04/22/2024, indicated the resident was a smoker or user of tobacco products two to five times per day. Per the Smoking- Safety Screen, the resident could light their own cigarettes and required a smoking apron, a cigarette holder, supervision, and one-on-one assistance. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/27/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated the resident used tobacco at the time of the assessment. Resident #32's comprehensive care plan revealed it did not address the resident's smoking status or the assessed needs of the resident related to smoking. Observation on 05/07/2024 at 8:45 AM revealed Resident #32 was outside smoking in the designated smoking area with staff supervision . During an interview on 05/08/2024 at 1:44 PM, the MDS Coordinator stated if a resident smoked, they needed a care plan that indicated what type of supervision they required, what adaptive equipment was needed, and other safety interventions such as putting cigarettes out in the proper disposal areas. During an interview on 05/08/2024 at 2:55 PM, Licensed Vocational Nurse (LVN) #6 stated a resident that smoked should have a care plan that addressed smoking supervision and any needed equipment. During an interview on 05/09/2024 at 8:00 AM, the Director of Nursing (DON) stated if a resident smoked, they should have a care plan that reflected safety and cessation interventions and any adaptive equipment the resident required. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/2024 at 8:20 AM, the Administrator stated if a resident smoked, their care plan should address smoking, including information on safety, the resident's compliance, and any needed supervision. 28196 2. An Admission Record revealed the facility admitted Resident #46 on 02/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of quadriplegia and muscle wasting and atrophy. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/04/2024, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had a functional limitation in range of motion on both sides of their upper and lower extremities and was dependent on staff for all ADLs. Resident #46's comprehensive care plan revealed a Focus area, initiated on 12/26/2023, that indicated the resident had impaired ADL function and required assistance with ADLs; however, the care plan did not address the level of assistance the resident required. A Focus area, initiated on 03/01/2024, indicated the resident demonstrated decreased strength and balance for safe bed mobility, transfers, and gait. Another Focus area, initiated on 03/01/2024, indicated the resident was at risk for skin breakdown and included an intervention dated 03/01/2024 that directed staff to assist with toileting needs if needed. Resident #46' care plan did not specify the level of assistance the resident required from staff with the performance of ADLs. During an interview on 05/08/2024 at 2:06 PM, the MDS Coordinator stated it was important for care plans to address ADLs, so staff know how to care for the residents. After reviewing Resident #46's care plan, the MDS Coordinator confirmed the resident's care plan did not address the level of assistance they required with ADLs. During an interview on 05/09/2024 at 8:02 AM, the Director of Nursing (DON) stated if a resident was dependent on staff for their ADLs, the level of assistance required with their ADLs should be reflected on their care plan, so staff knew how to care for them. The DON confirmed Resident #46 was dependent on staff for all ADLs and indicated the resident's care plan should address the level of assistance the resident required. During an interview on 05/09/2024 at 8:23 AM, the Administrator stated if a resident was dependent on staff for ADLs, the level of assistance required with ADLs should be reflected on their care plan. He said care plans should reflect how to take care of the residents. The Administrator said the importance of care planning was so that staff knew what level of assistance and care the residents needed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 28196 Based on observation, record review, and facility policy review, the facility failed to ensure staff provided assistance with activities of daily living (ADLs) for 2 (Resident #44 and Resident #46) of 2 residents reviewed for ADLs. Findings included: A facility policy titled, Activities of Daily Living (ADLs), Supporting, revised in 03/2018, indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy further indicated, 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care). 1. An Admission Record revealed the facility admitted Resident #44 on 12/26/2023. According to the Admission Record, the resident had a medical history that included diagnoses of transient cerebral ischemic attack (a brief stroke-like attack) and muscle wasting and atrophy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was totally dependent on staff for personal hygiene, including combing their hair. Resident #44's comprehensive care plan included a Focus area, initiated on 12/26/2023, that indicated the resident had impaired ADL function and required assistance with ADLs. On 05/06/2024 at 10:02 AM, Resident # 44 was observed lying in bed with their hair very disheveled. On 05/07/2024 at 9:12 AM, Resident #44 was observed lying in bed and their hair was again disheveled. During an interview on 05/08/2024 at 10:45 AM, the Director of Nursing (DON) stated she expected staff to provide ADL care during morning care. After observing Resident #44, she confirmed Resident #44 needed their hair groomed and said she would get their aide to take care of it. During an interview on 05/08/2024 at 11:27 AM, Certified Nurse Assistant (CNA) #5 stated that once staff got residents dressed, they then brushed their teeth and hair. She indicated she usually got Resident #44 dressed after breakfast, then brushed their hair. She further said that on the morning of 05/08/2024, she dressed Resident #44 after breakfast but did not brush the resident's hair because she forgot. During an interview on 05/09/2024 at 8:23 AM, the Administrator said Resident #44 was dependent on staff for hair care and their hair needed to be groomed daily. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An Admission Record revealed the facility admitted Resident #46 on 02/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of quadriplegia and muscle wasting and atrophy. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/04/2024, revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had a functional limitation in range of motion on both sides of their upper and lower extremities and was dependent on staff for personal hygiene. Resident #46's comprehensive care plan included a Focus area, initiated on 03/01/2024, that indicated the resident had a potential for decline in self-care skills. The Goal indicated Resident #46 would demonstrate grooming and personal hygiene with moderate assistance by staff, with a target ate of 05/29/2024. The interventions indicated the resident was receiving occupational therapy five times per week for four weeks but did not reflect the level of assistance the resident currently required from staff for grooming and personal hygiene. In addition, the comprehensive care plan did not address the resident's need for routine nail care. On 05/06/2024 at 12:20 PM, Resident #46's fingernails and toenails were observed. The resident's fingernails were long, jagged, and extended approximately an eighth of an inch past the pads of their fingers. The resident's toenails were thick, discolored, and long. On 05/08/2024 at 8:16 AM, Resident #46's fingernails were observed, and they remained long and jagged and had a brown substance under them. Licensed Vocational Nurse (LVN) #1 and Certified Nurse Assistant (CNA) #2, who were providing care to the resident at the time, were asked who was responsible for providing nail care for Resident #46. LVN #1 stated they had an in-house podiatrist that did residents' toenails, and the aides did their fingernails. After observing Resident #46's nails, LVN #1 and CNA #2 agreed the resident's nails needed to be addressed. Resident #46 said their nails had not been trimmed since they were admitted to the facility and stated they would like for them to be trimmed. During an interview on 05/08/2024 at 10:19 AM, CNA #3 stated that the aides provided the residents' nail care. She indicated the aides provided nail care when they noticed they needed to be done. She further indicated she had never done Resident #46's nails. During an interview on 05/09/2024 at 8:02 AM, the Director of Nursing (DON) stated Resident #46 was dependent on staff for all their ADLs, and the resident's nails should be cleaned and trimmed as needed. During an interview on 05/09/2024 at 8:23 AM, the Administrator stated Resident #46 was dependent on staff for nail care and indicated the resident's nails should have been addressed by staff prior to a surveyor pointing out the concern.