STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555711	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care on Palm	4768 Palm Avenue Riverside, CA 92501

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care plan was initiated and/or developed to address the diagnoses of epistaxis (bleeding from the nose) for one of one residents reviewed for quality of care (Resident 1).This failure had the potential for Resident 1 to not be monitored for epistaxis complications and delayed treatment, increasing the risk of further harm. Findings:On November 25, 2025, at 8:00 a.m. an unannounced visit was conducted at the facility to investigate a facility reported incident.On November 25, 2025, at 8:00 a.m., an observation with a concurrent interview was conducted with Resident 1. Resident 1 was observed in bed, alert and interviewable. Red stains resembling blood were observed on Resident 1's gown, specifically in the chest area. Similar stains were also noted on a washcloth located beside Resident 1. Resident 1 stated she experienced nose bleeds often. On November 25,2025, at 8: 15a. m, an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 1 had episodes of nose bleeding since she started working at the facility about a month ago. LVN 1 stated Resident 1's episodes of nose bleeds have been referred to her primary physician.On November 25, 2025, Resident 1's record was reviewed. Resident 1 was readmitted to the facility on [DATE] with diagnoses including Right Distal Femur Fracture (broken leg).The Nurse Practitioner (NP) progress notes, dated November 4, 9, 12, 16, 19, and 24, 2025, indicated Resident 1 had epistaxis. There was no documented evidence that a care plan was developed to address Resident 1's epistaxis during these dates.On November 25,2025 at 9:30 a.m. , an interview with a concurrent record review was conducted with the Director of Nursing (DON). The DON stated:- Resident 1 had history of nose bleeding prior to her hospitalization on November 4, 2025;-Resident 1 had epistaxis as noted by the NP on November 4, 9, 12, 16, 19, and 24, 2025;-Resident 1 was being monitored for the side effects of anticoagulant (blood-thinning medicine that helps prevent clots) and antiplatelet (medicine that prevents blood cells from sticking together to make clots) medication, such as nosebleeds. The electronic Medication Administration Record (eMAR) dated November 1 to 30, 2025, showed no episodes of nose bleeds from November 9 to 25, 2025.- There was no documentation the licensed nurses identified and referred to the physician Resident 1's episodes of epistaxis from November 9 to 24, 2025;- There was no care plan developed or initiated to address Resident 1's epistaxis since she was re-admitted from the acute hospital on November 4, 2025; and- A care plan should have been initiated on November 4, 2025, to monitor Resident 1's need for interventions to address epistaxis. In addition, a care plan was needed to communicate the plan of care to address Resident 1's epistaxis. The facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated and revised in December 2016, indicated, .Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence .Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition .When the resident has been readmitted to the facility from a hospital/rehabilitation stay; and at least quarterly .

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two residents reviewed for breathing treatment therapy (Residents 4 and 2), were monitored during and after nebulizer treatments (breathing treatments that turn liquid medicine into a mist).This failure placed the residents at risk for delayed treatment related to possible complications of the nebulizing treatment such as rapid heart rate, restlessness, chest pain and/or difficulty breathing.Findings:1.On November 25, 2025, at 8:30 a.m., and observation was conducted with Resident 4. Resident was in bed, alert, and non-verbal. A nebulizer mask (mask used to breathe in medicated mist) was observed connected over her nose and mouth. The medication chamber (small cup that holds the liquid medicine) was observed empty. There was no licensed nurse observed beside Resident 4.On November 25, 2025, at 8:45 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated she should have stayed in the room with Resident 4 during the breathing treatment per facility policy. On November 25, 2025, at 9:10 a.m., an observation with a concurrent interview was conducted with LVN 1. She stated she was the licensed nurse assigned to Resident 4 and she administered the breathing treatment (misted medication session) at 8:00 a.m. LVN 1 stated each breathing treatment last approximately 15-20 minutes. LVN 1 stated she had left the room because another resident had called for assistance. LVN 1 stated the correct procedure was to remain with the resident during the breathing treatment to observe for difficulty breathing (trouble catching their breath). LVN 1 stated the possible outcome of leaving the mask on the resident after the medication was gone was that the resident may become anxious, have trouble breathing, or refuse the next treatment. On November 25, 2025, at 9:10 a.m. LVN 1 was observed removing the nebulizing mask off Resident 4.On November 25, 2025, Resident 4's record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnosis including hypoxia (low oxygen level in the blood).The physician's order dated December 4, 2024, indicated to administer . Albuterol Inhalation Solution 0.5-2.5 (3) MG(milligram-unit of measurement)/3(ML) (millimeter-unit of measurement) (Ipratropium-Albuterol) 1 Vial (nebulizer medication treatment/misted medication) . To be given three times a day for shortness of breath. The electronic Medication Administration Record (eMAR) dated November 25, 2025, indicated LVN 1 administered the medication Albuterol to Resident 4 at 8 a.m.On November 25, 2025 at 9:30 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the licensed nurse was expected to remain with the resident during breathing treatment and remove the nebulizer face mask when the treatment was completed. 2. On November 25, 2025, at 8:54 a.m., an observation was conducted with Resident 2. Resident 2 was observed in bed, alert and oriented. Resident 2 had a nebulizer face mask in place with no medication solution remaining in the medication chamber. Resident 2 was observed with no licensed nurse present at bedside. On November 25, 2025, at 9:10 a.m., an interview was conducted with LVN 2. LVN 2 stated the correct way to administer a nebulizer treatment (breathing-mist medication) is to observe the resident for any difficulty breathing (trouble catching their breath) and remain with the resident during medication administration. LVN 2 stated it was not acceptable to leave the mask on Resident 2 for an hour because there is no medication solution left. LVN 2 stated she gave the breathing treatment medication, left the resident, and did not turn off the machine until 9:10 a.m. LVN 2 stated the possible outcome of leaving the mask on for that length of time is the resident might become anxious and refuse the next breathing treatment. LVN 2 stated she left the room because she was called out to assist another resident. LVN 2 stated that Resident 2 had the face mask on for an hour. LVN 2 stated each breathing treatment (mist medication session) lasts approximately 15 minutes. On November 25, 2025, Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnosis including Chronic Respiratory Failure with Hypoxia (low oxygen in the blood)A physician order dated April 4, 2025, indicated to administer, .Budenoside Inhalation suspension (breathing treatment medication) 0.5 MG (milligrams- unit of measurement)/2ML (milliliters - unit of measurement) 1 mg inhale two times a day related to for Chronic Obstructive Pulmonary Disease with Exacerbation (a long-term lung disease that makes it hard to breath, with a recent flare-up/worsening episode) . The electronic Medication Administration Record (eMAR) dated November 25, 2025 indicated LVN 2 administered the medication Budenoside at 8:00 a.m. On November 25,2025 at 9:30 a.m., an interview was conducted with the Director of Nursing (DON) The DON stated the licensed nurse should have removed Resident 2's nebulizer face mask once the medication was completed and monitored the resident during and after the treatment for any signs of difficulty breathing