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	04/16/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when:1. [NAME] 1 was performing food preparation without a beard restraint and the Dietary Aide had bangs exposed outside the hairnet while working in the kitchen.2. The stovetop was covered with a thick, crusty layer of black and brown grease.3. The interior and exterior surfaces of the oven were coated with heavy, dark buildup, exterior side of the oven door and its handle were coated with thick, heavy residue of old grease and dark deposits, and the bottom part of the oven was coated in a layer of sticky dust and oil residue.These failures had the potential to expose residents who received food from the kitchen to contaminants and could put them at risk of food-borne illnesses.4. An opened, unsealed bag of brown sugar was found unlabeled and undated.This failure had the potential for the food product to go bad, become contaminated, or attract pests to the kitchen.Findings:1. During an observation in the kitchen on 4/13/2026, at 7:53 AM, [NAME] 1 was performing food preparation without a beard restraint and the Dietary Aide had bangs exposed outside the hairnet while working in the kitchen. During an interview on 4/16/2026, at 8:24 AM, with the Assistant Dietary Services Supervisor (ADSS), ADSS stated kitchen staff should always be wearing hair nets and beard restraints properly. ADSS stated facility protocol required kitchen staff to have their hair completely covered. During a concurrent interview and record review on 4/16/2026, at 8:24 AM, with ADSS, the facility's undated Policy & Procedure (P&P) titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices was reviewed. The P&P indicated, Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. ADSS stated that kitchen staff should be wearing hair and beard nets properly at all times. 2. During a concurrent observation of the kitchen and interview on 4/13/2026, at 7:57 AM with ADSS, the kitchen stove was covered with a thick, crusty layer of brown and black grease. The ADSS confirmed the stove was covered with grease.3. During a concurrent observation and interview on 4/13/2026 at 7:57 AM with ADSS, the interior and exterior surfaces of the oven were coated with heavy, dark buildup. The exterior side of the oven door and its handle were coated with thick, heavy residue of old grease and dark deposits, and the bottom part of the oven was coated in a layer of sticky dust and oil residue. The ADSS verified these findings and acknowledged that the oven surfaces had not been maintained and were coated with old grease and oil buildup.During a concurrent interview and record review on 4/13/2026, at 3:30 PM, with ADSS, the facility's undated P&P titled, Sanitization was reviewed. The P&P indicated, All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions. The ADSS acknowledged the stove and oven required cleaning.4. During a concurrent observation of the kitchen and interview on 4/13/2026, at 7:59 AM, with ADSS, an opened, unsealed bag of brown sugar was found unlabeled and undated. The ADSS confirmed the bag of brown sugar should be labeled and dated.A review of the facility's undated P&P titled, Food Storage (Dry, Refrigerated, and Frozen) indicated, All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded.

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for five of five sampled residents (Residents 36, 53, 41, 21, and 1) on psychotropic (affecting brain activities associated with mental processes and behavior) medications. This failure had the potential for residents or their representatives to not be fully informed of the risks and benefits of psychotropic medications before receiving treatment.Findings: 1. A review of Resident 36's physician's orders indicated Resident 36 had orders for the following psychotropic medications: - Sertraline (generic for Zoloft, a psychotropic medication to treat depression) 50 milligrams (mg) by mouth one time a day for depression, dated 4/4/25; - Lorazepam (generic for Ativan, a psychotropic medication to treat anxiety) 0.5 mg by mouth two times a day for anxiety, dated 7/21/25 and 4/3/26; - Divalproex (generic for Depakote, a psychotropic medication to treat mood disorders) delayed release (DR) 1000 mg by mouth at bedtime for bipolar disorder (mood disorder that causes intense mood swings), dated 3/15/26; and - Trazodone (generic for Desyrel, a psychotropic medication to treat depression) 150 mg by mouth at bedtime for depression, dated 2/11/26. During a concurrent interview and record review on 4/15/26 at 12:13 PM with the Director of Nursing (DON), Resident 36's psychotropic informed consent forms, dated 9/21/24 to 1/12/25, were reviewed. The records indicated no evidence of informed consent for the ordered doses of sertraline, lorazepam, divalproex, or trazodone. The DON stated there were no additional informed consents for Resident 36. 2. A review of Resident 53's physician's orders, dated 11/26/25, indicated Resident 53 had orders for risperidone (generic for Risperdal, a psychotropic medication to treat mental illness) 1.75 mg by mouth at bedtime for schizophrenia (a mental illness characterized by disturbances in thought). During a concurrent interview and record review on 4/15/26 at 4:48 PM with the DON, Resident 53's Psychotherapeutic Drug Informed Consent Form, dated 4/3/26, was reviewed. The record indicated informed consent for Resident 53's risperidone was obtained on 4/3/26, after the date on the initial order. The DON stated this was the only informed consent the facility had for Resident 53. 3. A review of Resident 41's medication administration record (MAR, daily documentation record used by nurses to document medications and treatments given to a resident), dated March 2026, indicated Resident 41 had orders for the following psychotropic medications: - Escitalopram (generic for Lexapro, a psychotropic medication to treat depression) 15 mg by mouth one time a day for depression, dated 12/2/25; - Lithium carbonate (a psychotropic medication to treat mental illness and mood disorders) 600 mg by mouth at bedtime for schizophrenia, dated 12/12/25; - Chlorpromazine (generic for Thorazine, a psychotropic medication to treat mental illness) 75 mg by mouth two times a day for schizophrenia, dated 12/2/25; and - Haloperidol (generic for Haldol, a psychotropic medication to treat mental illness) 10 mg by mouth two times a day for schizophrenia, dated 2/13/26. A review of Resident 41's physician's orders indicated additional orders for lithium carbonate, Give 600 mg by mouth one time a day for schizophrenia, dated 4/8/26. During an interview on 4/15/26 at 4:54 PM with the DON, the DON stated the facility did not have documented informed consent for Resident 41's psychotropic medications. 4. A review of Resident 21's physician's orders, dated 1/25/25, indicated Resident 21 had orders for haloperidol decanoate (generic for Haldol Decanoate, a long-acting injectable psychotropic medication given every four weeks to treat mental illness) 100 mg per milliliter (ml). During an interview on 4/16/26 at 8:18 AM with the DON, the DON stated the facility did not have documented informed consent for Resident 21's psychotropic medication. 5. A review of Resident 1's NAQ - Psychotropic Assessment, dated 3/4/26, indicated the physician ordered Zyprexa (brand name for olanzapine, a psychotropic medication to treat mental illness) 10 mg injection every eight hours as needed for schizophrenia. A review of Resident 1's physician's orders, dated 3/17/26, indicated Resident 1 had additional orders for Zyprexa, Inject 10 mg intramuscularly [into the muscle] every 8 hours as needed for schizophrenia. A review of Resident 1's Psychotherapeutic Drug Informed (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Consent Form, dated 3/28/26, indicated informed consent for Resident 1's Zyprexa was obtained on 3/28/26, after the date on the initial orders. During an interview on 4/15/26 at 11:19 AM with the DON, the DON stated the facility needed to obtain informed consent before starting psychotropic medications for residents. The DON stated informed consent was supposed to be obtained for new psychotropic medication orders or whenever the dose was increased. A review of the facility's policy and procedure (P&P) titled, Informed Consent for Psychotropic Drugs, undated, indicated: This policy.outlines responsibilities for obtaining, verifying, and documenting informed consent to protect resident rights, promote safety, and facilitate appropriate use of these medications. This policy applies to all residents.prescribed psychotropic drugs, including new initiations, dose increases, or changes. Obtain informed consent for all psychotropic medications prior to initiation or dose increase. Document the discussion, resident/representative's understanding, and consent/refusal in the medical record. Facility Role: Verify (but not obtain) informed consent; ensure documentation in the medical record . and Initiation or Dose Increase: Prescriber obtains consent before administration. A review of the facility's P&P titled, Psychotropic Medication Use, dated 1/6/25, indicated, Informed Consent or Refusal.Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review.with the resident/representative prior to obtaining documented consent or refusal.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 17.14% when six medication errors occurred out of 35 opportunities during the medication administration observation for four out of five residents (Residents 28, 7, 6, and 40). These failures resulted in medications not given according to the physician's orders and had the potential for residents to not receive the full therapeutic effect of medications. These failures also had the potential for blockages to develop in Resident 6's gastrostomy tube (G-tube or feeding tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). Findings: 1. During a medication pass observation on 4/14/26, at 8:14 AM, at Resident 28's bedside, Licensed Vocational Nurse 5 (LVN 5) was observed administering nine medications to Resident 28. The medications included two 125 milligram (mg) capsules of delayed release divalproex (generic for Depakote Sprinkles, a medication to treat mood disorders) for a dose of 250 mg. A review of Resident 28's physician's orders, dated 4/3/26, indicated Resident 28 had orders for Divalproex Sodium Oral Tablet Delayed Release (generic for Depakote, a medication to treat mood disorders), Give 500 mg by mouth two times a day for Bipolar disorder [mood disorder that causes intense mood swings]. During an interview on 4/14/26, at 11:43 AM, with LVN 5, LVN 5 stated she gave 250 mg of divalproex capsules to Resident 28 during the morning medication pass. LVN 5 verified Resident 28 was supposed to get 500 mg of divalproex delayed release tablets. 2. During a medication pass observation on 4/14/26, at 8:27 AM, at Resident 7's bedside, LVN 5 was observed administering nine medications to Resident 7. The medications included one 100 mg capsule of gabapentin (generic for Neurontin, a medication to treat nerve pain). A review of Resident 7's physician's orders, dated 3/16/26, indicated Resident 7 had orders for Gabarone [brand name for gabapentin] Oral Tablet 100 MG, Give 100 mg by mouth two times a day for Nerve Pain. During an interview on 4/14/26, at 11:31 AM, with LVN 5, LVN 5 stated she gave Resident 7 a gabapentin capsule during the morning medication pass. LVN 5 stated she was supposed to give Resident 7 a gabapentin 100 mg tablet. During an interview on 4/15/26, at 10:03 AM, with LVN 4, LVN 4 stated nurses needed to call the physician before switching between dosage forms such as capsules and tablets. LVN 4 stated the physician could have ordered the specific dosage form because of a resident's ability to swallow or another clinical reason. 3a. During a medication pass observation on 4/14/26, at 9:16 AM, at Resident 6's bedside, LVN 5 was observed administering eight medications to Resident 6 through the G-tube. The medications included 7.5 milliliters (ml) of ferrous sulfate (iron supplement) 220 mg per 5 ml. A review of Resident 6's physician's orders, dated 3/17/26, indicated Resident 6 had orders for Iron Oral Liquid (Iron Glycinate [iron supplement]), Give 7.5 ml via G-Tube one time a day for supplement. During an interview on 4/14/26, at 11:25 AM, with LVN 5, LVN 5 stated she gave Resident 6 ferrous sulfate during the morning medication pass. LVN 5 stated Resident 6 had orders for iron glycinate, not ferrous sulfate. LVN 5 stated she did not give iron glycinate as ordered by the physician. During an interview on 4/15/26, at 10:35 AM, with the Director of Staff Development (DSD), the DSD stated nurses were expected to contact the physician to ask about changing the medication before administration. 3b. During a concurrent observation and interview on 4/14/26, at 9:16 AM, with LVN 5, outside Resident 6's room, LVN 5 prepared eight medications for Resident 6's medication pass. The medications included three liquids: ferrous sulfate, valproic acid (generic for Depakene, a medication to treat mood disorders), and levetiracetam (generic for Keppra, a seizure medication). LVN 5 verified she prepared three liquids for Resident 6's morning medication pass. A review of Resident 6's physician's orders, dated 5/12/22, indicated Resident 6 had orders for docusate liquid (generic for Colace, a medication to treat constipation) 50 mg per 5 ml, Give 10 ml via G-Tube two times a day for constipation. During an interview on 4/14/26, at 11:25 AM, with LVN 5, LVN 5 stated Resident 6 was supposed to get docusate during the morning medication pass. LVN 5 stated the docusate was not given. 3c. During a medication pass observation on 4/14/26, at 9:16 AM, at Resident 6's bedside, LVN 5 was observed administering eight medications to Resident (continued on next page)

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	555711	A. Building B. Wing	04/16/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6 through the G-tube. LVN 5 first put 30 ml of water into Resident 6's G-tube (also known as a G-tube flush). LVN 5 then administered each medication one at a time through the G-tube. LVN 5 did not flush the G-tube between each medication. After all medications were given, LVN 5 flushed the G-tube with 30 ml of water. During an interview on 4/14/26, at 10:04 AM, with LVN 5, LVN 5 stated G-tube medications were given one at a time. LVN 5 further stated the G-tube was supposed to be flushed before starting the G-tube medication pass and after all the medications were given. LVN 5 verified she did not flush the G-tube between each of Resident 6's medications. During an interview on 4/15/26, at 10:43 AM, with the DSD, the DSD stated nurses were supposed to flush the G-tube with 10 ml of water between each medication during medication pass. The DSD stated flushing the G-tube between medications was important to prevent clogs. During a concurrent interview and record review on 4/15/26, at 12:30 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Administering Medications through an Enteral [into the body through the mouth or feeding tube] Tube, dated November 2018, was reviewed. The P&P indicated, If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications. The DON stated nurses were supposed to flush the G-tube with water between each medication during medication pass. 4. During a concurrent interview and medication pass observation on 4/14/26, at 3:42 PM, outside Resident 40's room, LVN 3 was observed administering five medications to Resident 40. The medications were one tablet each of divalproex extended release 500 mg, lisinopril (a medication to treat high blood pressure) 20 mg, metformin (a medication to treat diabetes) 1000 mg, olanzapine (an antipsychotic medication to treat mental illness) 10 mg, and sodium chloride (a supplement) 1 gram (gm, unit of measurement). LVN 3 verified she gave five medications to Resident 40 for the afternoon medication pass. A review of Resident 40's physician's orders, dated 3/23/26, indicated Resident 40 had orders for quetiapine (generic for Seroquel, an antipsychotic medication to treat mental illness) 200 mg, Give 200 mg by mouth two times a day for Schizophrenia. A review of Resident 40's medication administration record (MAR, daily documentation record used by nurses to document medications and treatments given to a resident), dated April 2026, indicated Resident 40's quetiapine was ordered to be given two times a day at 8:00 AM and 4:00 PM. During an interview on 4/14/26, at 4:58 PM, with LVN 3, LVN 3 stated she did not give quetiapine to Resident 40. LVN 3 stated she was supposed to give the medication during the afternoon medication pass. During an interview on 4/15/26, at 10:48 AM with the DSD, the DSD stated it was always the expectation for nurses to follow physician orders. During an interview on 4/15/26, at 12:20 PM, with the DON, the DON stated the nurse needed a reason to omit a medication and the nurse needed to notify the provider. A review of the facility's P&P titled, Administering Medications, dated April 2019, indicated, Medications are administered in accordance with prescriber orders.

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	555711	A. Building B. Wing	04/16/2026

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of six residents (Resident 47) was treated with dignity and respect when a Certified Nursing Assistant (CNA 1) stood over the resident while feeding her.This failure had the potential to cause diminished dignity, loss of individuality, and decreased psychosocial well-being during the dining experience for Resident 47.Findings:A review of Resident 47's admission Record (demographic clinical information) indicated the resident was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction, unspecified (blood clot cuts off blood flow to a part of the brain), Schizophrenia, unspecified (a brain disorder that causes people to interpret reality abnormally often resulting in disorganized thinking), and Depression.During an observation on 4/13/26, at 12:56 PM, in Resident 47's room, CNA 1 was observed feeding Resident 47 lunch while standing over the resident, who was seated in a wheelchair. CNA 1 continued to feed Resident 47 with a spoon while standing.During an interview with CNA 1 on 4/13/26, at 1:05 PM, CNA 1 stated she was expected to obtain a chair and sit while assisting Resident 47 with meals. CNA 1 further stated that sitting beside the resident at eye level was important for resident comfort. CNA 1 acknowledged she should have obtained a chair and been seated while feeding the resident.During an interview with the Director of Staff Development (DSD) on 4/13/26, at 2:25 PM, the DSD stated staff were expected to position themselves at the resident's eye level when providing feeding assistance. The DSD stated CNA 1 should have obtained a chair and sat beside Resident 47 while assisting with the meal to prevent the resident from feeling intimidated.A review of the facility's policy and procedure (P&P) titled, Quality of Life-Dignity, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being level of satisfaction with life, feeling of self-worth and self-esteem.1. Resident are treated with dignity and respect at all times.A review of the facility's P&P titled, Assistance with Meals, revised July 2017, indicated, 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example.a. not standing over resident while assisting them with meals.

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	555711	A. Building B. Wing	04/16/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) was free from unnecessary psychotropic medications (medications that affect brain activities associated with mental processes and behavior) when Resident 1 received an as needed antipsychotic medication (type of psychotropic medication) without physician evaluation. This failure had the potential for Resident 1 to inappropriately receive an as needed antipsychotic medication and had a risk of medication side effects, such as sedation and falls. Findings: A review of Resident 1's admission record, dated 4/16/26, indicated Resident 1 was initially admitted to the facility on [DATE]. The admission record indicated Resident 1's diagnoses included schizophrenia (a mental illness characterized by disturbances in thought). A review of Resident 1's physician's orders, dated 3/17/26, indicated Resident 1 had renewed orders for Zyprexa (brand name for olanzapine, an antipsychotic medication to treat mental illness) 10 milligram (mg) injection, Inject 10 mg intramuscularly [into the muscle] every 8 hours as needed for Schizophrenia [a mental illness characterized by disturbances in thought] m/b [manifested by] verbal/physical aggression for 14 Days. During an interview on 4/16/26 at 2:35 PM with the Director of Nursing (DON), the DON stated there was no physician evaluation of Resident 1 for the renewed as needed (PRN) antipsychotic medication ordered on 3/17/26. The DON acknowledged the physician was supposed to evaluate Resident 1 before ordering the PRN Zyprexa. A review of the Prescribing Information (PI, detailed description of a medication available to clinicians) for Zyprexa injection, dated 2/11/26, retrieved from DailyMed, indicated somnolence [sleepiness] as an adverse reaction. A review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 1/6/25, indicated, PRN orders for psychotropic medications are limited to 14 days.For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS, a resident assessment tool) for two of five sampled residents (Residents 21 and 53). This failure had the potential for Residents 21 and 53 to not receive necessary care or services related to their antipsychotic medications (medications to treat mental illness). Findings: 1. A review of Resident 21's MDS Section N - Medications, dated 2/25/26, indicated Resident 21 was receiving antipsychotic medication at the time of the assessment. The record further indicated the physician documented gradual dose reduction (GDR, stepwise tapering of a medication to determine if symptoms can be managed at a lower dose) of the antipsychotic was contraindicated on 8/14/23. During a concurrent interview and record review on 4/16/26 at 8:46 AM with the MDS Coordinator (MDSC), Resident 21's Plan of Care Note, dated 2/13/26, and MDS Section N, dated 2/25/26, were reviewed. The MDSC stated the note indicated the prescriber documented GDR of Resident 21's antipsychotics was contraindicated. The MDSC stated the GDR date on the MDS was incorrect and needed to be corrected. 2. A review of Resident 53's MDS Section N - Medications, dated 3/2/26, indicated Resident 53 was receiving antipsychotic medication at the time of the assessment. The record further indicated the physician documented GDR of the antipsychotic was contraindicated on 9/14/23. During a concurrent interview and record review on 4/16/26 at 10:22 AM with the MDSC, Resident 53's Plan of Care Note, dated 2/13/26, and MDS Section N, dated 3/2/26, were reviewed. The MDSC stated the note indicated the prescriber documented GDR of Resident 53's antipsychotic was contraindicated. The MDSC stated the GDR date on the MDS was incorrect. During an interview on 4/16/26 at 10:42 AM with the MDSC, the MDSC stated the MDS was a comprehensive assessment of the resident at a specific point of time. The MDSC stated accuracy in the MDS was important to reflect accurate information and to know whether services were being provided. The MDSC further stated incorrect information in the MDS could lead to needed services not being provided to the resident. During an interview on 4/16/26 at 10:58 AM with the Director of Nursing (DON), the DON stated the MDS was expected to be accurate. When asked why the MDS needed to be accurate, the DON stated an inaccurate MDS was not current for the resident's care. A review of the facility's policy and procedure (P&P) titled, Comprehensive Assessments, dated October 2023, indicated, Comprehensive MDS assessments are conducted to assist in developing person-centered care plans and These assessments are used to develop, review and revise the resident's comprehensive care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an individualized care plan was developed when one of two residents (Resident 32) did not have a care plan for an actual fall.This failure had the potential to result in recurrent falls and serious injury due to lack of interventions to ensure Resident 32's safety following the initial fall event.Findings:1. A review of Resident 32's admission Record. (a document showing a summary of the resident's information) dated 4/15/2026 indicated Resident 32 was admitted to the facility on [DATE] with a diagnosis of abnormalities of gait and mobility.During an interview on 4/14/2026, at 8:23 AM, with Resident 32, Resident 32 stated I fell. Resident 32 stated that he lost his balance and fell while getting out of bed on the previous day.A review of Resident 32's Care Plan Report, undated, indicated there was no care plan problem related to Resident 32's fall incident on 4/13/2026. During a concurrent interview and record review on 4/15/2026, at 4:32 PM, with Licensed Vocational Nurse 6 (LVN 6) in the presence of Registered Nurse 1 (RN 1), Resident 32's Care Plan Report, undated, was reviewed. LVN 6 and RN 1 confirmed Resident 32 had an actual unwitnessed fall on 4/13/2026 and did not have a care plan developed for the fall.During a concurrent interview and record review on 4/15/2026, at 4:52 PM, with the Minimum Data Set Coordinator (MDSC), Resident 32's Care Plan Report, undated, was reviewed. The MDSC confirmed that no care plan was developed for Resident 32 following the fall on 4/13/2026. MDSC further clarified that a short-term care plan should have been documented and initiated by RN 1.A review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, undated, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.A review of the facility's P&P titled, Falls and Fall Risk, Managing, undated, indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

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	04/16/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure accurate accountability of controlled medications (controlled substances [CS], those with high potential for abuse and addiction) when the Controlled Substance Records (CSR, accountability records) for one of three randomly selected residents (Resident 41) did not reconcile with the Medication Administration Records (MAR, daily documentation record used by a licensed nurse to document medications and treatments given to a resident). This failure resulted in inaccurate accountability of controlled substances and the potential for unidentified discrepancies and possible abuse or diversion of controlled substances. Findings:A review of Resident 41's physician's orders, dated 3/19/26, indicated Resident 41 had orders for tramadol (a controlled medication for pain) 50 milligrams (mg), Give 1 tablet by mouth every 6 hours as needed for severe pain. During a concurrent interview and record review on 4/14/26, at 4:10 PM, with Licensed Vocational Nurse 3 (LVN 3), Resident 41's CSR, dated 3/20/26, and MAR, dated March 2026, were reviewed. The CSR indicated nursing staff removed one tablet of tramadol 50 mg on 3/24/26 at 7:48 AM and one on 3/27/26 at 8:05 AM. The MAR indicated tramadol was not administered to Resident 41 on 3/24/26 or 3/27/26. LVN 3 stated Resident 41's MAR was missing documentation. LVN 3 stated it looked like the tramadol was not given to Resident 41 on 3/24/26 or 3/27/26. LVN 3 stated the medication administration needed to be documented on the MAR. During an interview on 4/15/26, at 10:07 AM, with LVN 4, LVN 4 stated nurses were supposed to verify the counts of controlled substances at each shift change to identify discrepancies. LVN 4 stated nurses were supposed to document administration of controlled substances in the CSR and the MAR. LVN 4 stated the CSR and the MAR should match. During an interview on 4/15/26, at 10:35 AM, with the Director of Staff Development (DSD), the DSD stated the expectation was for nurses to sign out the controlled medication on the CSR and to document the administration in the MAR. The DSD stated the purpose of narcotic accountability procedures was to identify discrepancies. During an interview on 4/15/26, at 10:55 AM, with the Director of Nursing (DON), the DON stated the nurse was supposed to document the removed tramadol in both the CSR and the administration in the MAR. A review of the facility's policy and procedure (P&P) titled, Documentation of Medication Administration, dated April 2007, was reviewed. The P&P indicated, Administration of medication must be documented immediately after (never before) it is given.

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	04/16/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement infection prevention and control practices to provide a safe and sanitary environment when a used urinal was found on one of 49 residents (Resident 32)'s bedside table. This deficient practice had the potential to expose residents to infection-causing substances in the facility. Findings:During an observation on 4/13/2026, at 9:23 AM, a urinal with bloody urine was found on Resident 32's bedside table next to a water pitcher. Bloody urine was observed on the outside of the urinal near the opening at the top and the lid was open.During an observation on 4/13/2026, at 3:20 PM, a urinal with bloody urine was found on Resident 32's bedside table next to a water pitcher and an empty food tray. Bloody urine was observed on the outside of the urinal near the opening at the top, and the lid was open.During an interview on 4/13/26, at 3:23 PM, with Certified Nursing Assistant 2 (CNA 2), CNA 2 verified the urinal with urine was on Resident 32's bedside table next to an empty food tray and confirmed the urinal should not be stored there.During a concurrent interview and record review on 4/16/2026, at 11:51 PM, with the Infection Preventionist (IP), the facility's undated policy and procedure (P&P) titled, Policies and Practices - Infection Control was reviewed. The P&P indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The IP stated the policy was not followed when the urinal with bloody urine was found on Resident 32's bedside table.