STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555884	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Heights Healthcare Center, LLC	8951 Granite Hill Drive Riverside, CA 92509

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 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 observation, interview, and record review, the facility failed to identify adverse effects of psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) for one of six residents reviewed (Resident 44), when Resident 44 was administered Risperdal (an antispychotic medication) and was observed with a facial chewing motion. This failure had the potential for Resident 44 to have irreversible adverse effects such as extrapyramidal symptoms (EPS, movement disorders caused by certain medications, particulary antipsychotics). Findings: On June 16, 2025, at 12:04 p.m., Resident 44 was observed having a facial chewing motion while sitting at a table in the dining room. On June 18, 2025, at 1:50 p.m., a second observation of Resident 44 was conducted. Resident 44 was observed having a facial chewing motion while sitting in the dining room awaiting the start of an activity. A review of Resident 44's medical record was conducted on June 18, 2025. The medical record indicated Resident 44 was admitted to the facility on [DATE], with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and depression. Resident 44's medication administration record indicated Risperdal 2mg (mg-milligram a unit of measurement) by mouth at bedtime was started on June 23, 2023. Resident 44's medical record indicated EPS monitoring (an assessment for drug induced movements caused by psychotropic medication) every shift. The following dates for the month of June 2025, indicated zero (0-means no drug induced movements were observed) for every shift June 1, 2025, through June 18, 2025. Resident 44's AIMS (Abnormal Involuntary Movement Scale) dated June 3, 2025, indicated Resident 44 had none of the following AIMS, .Facial and Oral Movement .Lips puckering .smacking .Jaw Movement .chewing . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 44's Care Plan indicated .Focus .will be/remain free of psychotropic drug related complications . movement disorder . On June 18, 2025, at 2:16 p.m., a concurrent observation and interview was conducted with the assigned CNA (Certified Nurse Assistant). The CNA verified Resident 44 had facial chewing with no evidence of food or gum in the resident's mouth. The CNA further stated she did not know this was a sign of EPS. On June 18, 2025, at 2:21 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 verified Resident 44 had facial chewing with no evidence of food or gum in the resident's mouth. LVN 1 further stated she did not know this was a symptom of EPS. On June 18, 2025, at 2:30 p.m., a concurrent observation was conducted with the Director of Nursing (DON). The DON verified Resident 44 had facial chewing with no evidence of food or gum in the resident's mouth. The DON stated Resident 44 was demonstrating EPS. The DON further stated nursing should have been able to assess the signs and symptoms of EPS. A review of the facility's policy and procedure titled, Psychotropic Drugs, revised April 28, 2025, indicated When the interdisciplinary team and the physician agree that a psychotropic drug is indicated, the following documentation shall be included .The resident's care plan with duration and circumstances under which the drug is to be used, appropriateness of the clinical objectives and care plan interventions .data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment for one of two residents reviewed for oxygen administration (Resident 20), when the physician's order for oxygen administration was not followed. This failure had the potential to result in respiratory distress and decline in the resident's health condition. Findings: On June 16, 2025, at 10:45 a.m., Resident 20 was observed in his room, in bed, with oxygen (O2) via nasal cannula (NC - a tube used to deliver oxygen through the nose). Resident 20 was unable to communicate. Resident 20's oxygen administration was observed at 2.5 liters per minute (LPM - a unit of measurement). On June 18, 2025, at 9:12 a.m., Resident 20's record was reviewed. Resident 20 was re-admitted to the facility on [DATE], with diagnoses which included seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), Huntington's disease (an inherited disorder that causes nerve cells in parts of the brain to gradually break down and die), chronic respiratory failure (low oxygen in the blood), and dementia (a progressive state of decline in mental abilities). The physician's order dated October 14, 2024, indicated, .May use oxygen @ (at) 2-3L/min (LPM) via nasal cannula or face mask for oxygen saturation (a measure of the percentage of oxygen in the blood, normal range for healthy individuals between 95-100%) below 92% . On June 18, 2025, at 9:20 a.m., Resident 20 was observed in the activity room, without oxygen. Resident 20 was observed restless. Licensed Vocational Nurse (LVN) 1 was asked to check Resident 20's O2 saturation. Resident 20's O2 saturation was 80%. No portable O2 tank was observed available by Resident 20. LVN 1 stated Resident 20's O2 saturation is too low, and he needs O2. LVN 1 took Resident 20 back to his room to administer O2. On June 18, 2025, at 9:30 a.m., a concurrent interview and record review was conducted with LVN 1. LVN 1 reviewed the physician's order for Resident 20 and stated Resident 20 should have been on oxygen if his O2 saturation was below 92%. LVN 1 stated the physician's order was not followed for Resident 20. On June 18, 2025, at 10:20 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 20 should have been on O2 in the activities room, to maintain his O2 saturation above 92%, as per physician's order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy and procedure titled, Oxygen Therapy, revised November 2017, was reviewed. The policy indicated, .To deliver supplemental oxygen to aid the relief of tissue hypoxia (low levels of oxygen in the body tissues) or hypoxemia (abnormally low levels of oxygen in the blood) .It is the policy of this facility that oxygen therapy is administered as ordered by the physician or as an emergency measure until a physician order can be obtained .Read physician's orders .Obtain liter flow and mode of administering oxygen .Monitor oxygen usage frequently .Monitor resident for signs of shortness of breath, restlessness or other symptoms of oxygen deprivation .

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one out of five sampled residents (Resident 18) was free from unnecessary medications when Resident 18 received an antihypertensive medication (used to manage high blood pressure) outside of the prescribed blood pressure (BP) parameter four times in April 2025. This failure increased the potential for Resident 18 to experience side effects such as low BP, leading to further heart related complications. Finding: A review of Resident 18's admission Record, dated June 19, 2025 indicated the resident was initially admitted to the facility on [DATE] and recently readmitted on [DATE] with diagnoses including hypertension (high blood pressure), heart failure (serious condition when heart does not pump blood to the body efficiently), and cardiomyopathy (disease of the heart muscle), and atrial fibrillation (abnormal heart beat). A review of Resident 18's Care Plan Report, dated May 8, 2025, indicated the resident was at risk for hypotension (low BP) and indicated interventions including, Administer anti-hypertensive medications as ordered -metoprolol .Follow blood pressure parameters as ordered prior to administering medications. The BP is measured in millimeters of mercury (mmHg, unit of measurement) and in two numbers. The upper number is the systolic BP, or SBP, indicating the pressure in the arteries when the heart beats and pumps blood through the body; the lower number is the diastolic BP, or DBP, is the pressure in the arteries when the heart rests between beats. A review of Resident 18's clinical record indicated a physician's order, dated March 19, 2025, for metoprolol succinate ER (extended release, designed to release medication slowly) tablet 25 mg (milligram, unit of measurement), give one tablet one time a day for hypertension hold if SBP is below 110 [mmHg] . A review of Resident 18's Medication Administration Record (MAR), dated April 2025, indicated Resident 18 received metoprolol succinate ER when it should have been held (SBP, upper number, was below 110), on the following dates and times: - On April 3, 2025, at 7:30 a.m. with BP of 101/66; - On April 4, 2025, at 7:30 a.m. with BP of 106/65; - On April 19, 2025, at 7:30 a.m. with BP of 102/62; and - On April 20, 2025, at 7:30 a.m. with BP of 108/63. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on June 18, 2025, at 3:50 p.m., Resident 18's clinical record, including the MAR dated April 2025 was reviewed with the Director of Nursing (DON). The DON confirmed the above findings and acknowledged nursing staff should not have administered metoprolol succinate ER to Resident 18 when SBP was below 110 on the above dates and times. The DON stated the expectation was for nursing staff to have followed hold parameters as ordered by the physician. During a follow-up interview on June 19, 2025, with the DON, the DON stated it was important to follow the BP medication hold parameters to prevent dropping the resident's BP too low. A review of the Prescribing Information (PI, manufacturer's instructions) for metoprolol succinate extended release tablet, dated January 2025, retrieved from DailyMed (a public website maintained by the U.S. Food and Drug Administration), indicated, Most common adverse reactions: tiredness, dizziness, depression, shortness of breath (difficulty breathing), bradycardia (abnormally slow heart rate), hypotension (abnormally low blood pressure) . During a review of the facility's policy and procedure (P&P) titled, Procedure: Preparation of Doses - General Instructions, dated January 16, 2025, indicated, The nurse shall read and follow precautionary or additional instructions available on the prescription label (i.e. [example] .Parameters).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 8% when two medication errors occurred out of 25 opportunities during the medication administration for two of four residents (Residents 28 and 52). The facility did not administer the residents' prefilled insulin (medication for diabetes) pen injection according to the manufacturer's instructions. This failure had the potential to result in Residents 28 and 52 not receiving the full therapeutic benefit of their medications. Findings: 1a. During a medication pass observation on June 18, 2025, at 11:35 a.m., Licensed Vocational Nurse (LVN) 2 was observed preparing a prefilled Humalog (insulin lispro, brand name: Humalog KwikPen, medication for diabetes) 100 units/milliliter (ml, unit of measurement) pen for Resident 28. On June 18, 2025, at 11:39 a.m., LVN 2 was observed administering 4 units from the prefilled Humalog pen as a subcutaneous (under the skin) injection in Resident 28's lower right abdomen. LVN 2 pressed and immediately released the prefilled Humalog pen's dose knob without holding it in place for at least 5 seconds. A review of Resident 28's medical record indicated a physician's order, dated April 29, 2025, for Humalog Injection Solution 100 units/ml (Insulin Lispro), inject 4 units subcutaneously before meals. 1b. During another medication pass observation on June 18, 2025, at 11:51 a.m., LVN 2 was observed preparing a prefilled Lispro (insulin lispro, brand name: Lispro Kwikpen, medication for diabetes) 100 units/ml pen for Resident 52. On June 18, 2025, at 11:56 a.m., LVN 2 was observed administering 6 units from the prefilled Lispro pen as a subcutaneous injection in Resident 52's back of the right upper arm. LVN 2 pressed and immediately released the prefilled Lispro pen's dose knob without holding it in place for at least 5 seconds. A review of Resident 52's medical record indicated a physician's order, dated April 30, 2025, for Insulin Lispro Injection Solution 100 units/ml (Insulin Lispro), inject 6 units subcutaneously before meals. During an interview on June 18, 2025, at 12 p.m., LVN 2 acknowledged she did not hold the prefilled Humalog and Lispro pens' dose knob down for at least 5 seconds when administering the medication to Residents 28 and 52. LVN 2 stated she did not know she was supposed to hold the pens' dose knob down for at least 5 seconds. During a concurrent interview and record review on June 18, 2025, at 12:30 p.m. with the Director of Nursing (DON), the DON reviewed the prefilled Humalog and Lispro pens manufacturer's instructions from the manufacturer's website. The prefilled Humalog and Lispro pens manufacturer's instructions indicated, Continue to hold the dose knob in and slowly count to 5 before removing the needle. The DON stated nursing staff should have followed the manufacturer's instructions during the administration of prefilled Humalog pen for Resident 28 and prefilled Lispro pen for Resident 52. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on June 19, 2025, at 1:06 p.m., the DON stated it was important for nursing staff to administer the prefilled insulin pens according to the manufacturer's instructions to ensure the full dose was administered to the residents. A review of Humalog (Insulin Lispro) KwikPen manufacturer's Instructions for Use, dated May 2025 provided by the facility, indicated, Step 11 .Insert the Needle into your skin .Push the Dose Knob all the way in . Continue to hold the Dose Knob in and slowly count to 5 before removing the Needle. During a review of the facility's policy and procedure (P&P) titled, Subcutaneous medication administration procedures, dated January 16, 2025, indicated, Procedure .inject medication slowly .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure refrigerated medications and biologicals were stored at temperatures in accordance with facility policy and manufacturer's specifications when one of two medication refrigerators was identified with documented temperature readings below the normal range on multiple days between January to June 2025. This failure had the potential for residents to receive ineffective medications which could result in the residents not receiving the full benefit of the medications, leading to further health complications. Findings: During a concurrent observation and interview at nursing station 1 on June 16, 2025, at 2:15 p.m. with Registered Nurse (RN) 1, a medication refrigerator was identified. The refrigerator was observed to contain the following medications: - Afluria (flu vaccine) injectable suspension; - Latanoprost (used to lower pressure in the eye) eye drops; - Ozempic (used for diabetes and weight loss) prefilled pen; - Retacrit (used to produce more red blood cells) vial; - various types of insulin (used to treat diabetes) including Semglee (insulin glargine) prefilled pen; and - Tubersol PPD (test agent used in the diagnosis of tuberculosis) vial. During the same concurrent interview and observation on June 16, 2025, at 2:15 p.m., RN 1 stated the medications in the refrigerator should have been stored at 36 degree Fahrenheit (F, a temperature measurement) to 46 degree F. During this interview, the product labeling from the Ozempic carton (dated September 2023), reviewed with RN 1 indicated, .Storage Conditions for the Ozempic Pen .Refrigerated 36 degree F to 46 degree F. Additionally, RN 1 reviewed the medication refrigerator temperature logs dated January to June 2025 and acknowledged the medication refrigerator temperatures were below 36 degree F (out of range) against the manufacturer's instructions, on multiple days. RN 1 stated when the medication refrigerator was out of range, nursing staff needed to adjust the thermostat inside the refrigerator and should have reported to maintenance if temperature had not returned to normal range. RN 1 stated if medications were not stored according to the required temperature they could have been ineffective. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on June 16, 2025, at 3:09 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated nursing staff needed to document the medication refrigerator temperature on the log at every shift (morning and evening). LVN 3 stated the normal range for the medication refrigerator was between 36 degree F to 46 degree F. LVN 3 stated if the medication refrigerator temperature was out of range, nursing staff should have tried to adjust, rechecked temperature in one to two hours, then should have notified maintenance staff if the temperature was not back in range. A review of the Prescribing Information (PI, manufacturer's instructions) for Afluria (flu vaccine) injectable suspension, dated July 2024, retrieved from DailyMed (a public website maintained by the U.S. Food and Drug Administration), indicated, Store refrigerated at 2-8 degree Celsius [C, a temperature measurement] (36-46 degree F). A review of the PI for Latanoprost eye drops, dated June 2024, retrieved from DailyMed, indicated, Store unopened bottle(s) under refrigeration at 2 degree C to 8 degree C (36 degree F to 46 degree F). A review of the PI for Retacrit, dated September 2024, retrieved from DailyMed, indicated, Store refrigerated at 2 degree C to 8 degree C (36 degree F to 46 degree F). A review of the PI for Semglee (insulin glargine) prefilled pen, dated March 2025, retrieved from DailyMed, indicated, Not in-use (unopened) Refrigerated (2 degree to 8 degree C [36 degree to 46 degree F]). A review of the PI for Tubersol PPD, dated October 2021, retrieved from DailyMed, indicated, Store at 2 to 8 degree C (35 to 46 degree F). During a concurrent interview and record review on June 17, 2025, at 9:45 a.m. the facility's nursing station 1 medication refrigerator temperature logs dated January to June 2025 were reviewed with the Director of Nursing (DON). The DON stated nursing staff were expected to document the medication refrigerator temperature on the log twice a day at the beginning of each shift (morning and night) and the normal temperature range was between 36 degree F to 46 degree F according to the facility's policy. The DON confirmed the nursing station 1 medication refrigerator temperatures were below the normal range as follows: - In January 2025: 34 degree F on 14 days during morning shift; - In February 2025: 34 degree F on 15 days during morning shift, 25 degree F on one day (reported to maintenance by nursing staff) during morning shift, and 34 degree F on 6 days during night shift; - In March 2025: 34 degrees F on 15 days during morning shift, 35 degree F on one day during morning shift, and 34 degrees F on 10 days during night shift; - In April 2025: 34 degree F on 9 days during morning shift; - In May 2025: 34 degree F on 21 days during morning shift, 35 degree F on one day during morning shift, 34 degree F on two days during night shift, and 35 degree F on 5 days during night shift; and - In June 2025: 35 degrees F on one day during morning shift and one day during night shift. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same concurrent interview and record review on June 17, 2025, at 9:45 a.m., the DON acknowledged in April 2025, three days were missing a temperature recording during night shift and stated it should have been documented. The DON stated when temperatures were out of range, nursing staff were expected to adjust the thermostat inside the refrigerator and recheck in 15 minutes, then if the temperature was not back in range, they should have called maintenance and notify the DON. The DON stated it was important to ensure refrigerated medications were stored at the appropriate temperatures according to the manufacturer's instructions and facility policy because the effectiveness of the medication could have been altered and might not work as intended when administered to residents. During a review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated January 16, 2025, the P&P indicated, Medications requiring 'refrigeration' or 'temperature between 2 degree C (36 degree F) and 8 degree C (46 degree F)' are kept in a refrigerator with a thermostat to allow temperature monitoring.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide safe storage, preparation, and distribution of food when the kitchen staff performed the chlorine (a sanitizing solution) testing of the dishwashing machine with expired test strips. This failure had the potential to result in foodborne illness to a vulnerable facility population. Findings: On June 18, 2025, at 11:26 a.m., a concurrent observation and interview was conducted with the dietary aide (DA). The DA was observed to run the dishwasher and performed the chlorine test strip. The vial containing the test strips was observed with an expiration date of May 1, 2025. The DA stated the chlorine test strips were expired and should not have been used to test the level of the sanitizing solution from the dishwasher. On June 18, 2025, at 11:35 a.m., an interview was conducted with the Dietary Supervisor (DS). The DS stated the chlorine test strips were expired and should not have been used to test the level of the sanitizing solution from the dishwasher. On June 20, 2025, at 11:21 a.m., an interview was conducted with the Registered Dietician (RD). The RD stated if the chlorine test strips were expired, the kitchen staff was unable to tell if the dishwasher sanitizing solution was in the right concentration. The RD stated the kitchen staff should not have used expired test strips. The facility policy and procedure, titled, Dishwashing Machine Use, dated January 16, 2025, was reviewed. The policy and procedure indicated, .Test the sanitizing solution using the manufacturer's suggested test strips to assure appropriate .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On June 16, 2025, at 9:35 a.m., Resident 18 was observed lying in bed, awake, alert, and able to make his needs known. Resident 18 was receiving oxygen (O2) at 3 LPM (liters per minute - a unit of measurement) via the nasal cannula attached to an O2 concentrator (a machine that supplies oxygen). The nasal cannula was labeled with Resident 1's name, room number and date of 6/6/25. A wheelchair was observed at the foot of Resident 18's bed. Resident 18 stated he was using the wheelchair when he was up. An O2 cannula with no date was observed attached to a portable O2 tank. The O2 cannula was observed hanging on the back of the wheelchair, exposed to the environment. On June 16, 2025, at 9:46 a.m. Registered Nurse (RN) 2 was observed assisting Resident 18 in the room. In a concurrent interview with RN 2, she stated Resident 18's nasal cannula was dated 6/6/25. RN 2 stated she was not sure when the O2 cannula should have been changed. She stated Resident 18 was using the wheelchair located at the foot of the bed. She stated the O2 cannula in the wheelchair attached to the portable O2 tank did not have a date and was not stored in a plastic bag. RN 2 stated the O2 tubing should have been labeled and stored in a plastic bag for infection control. On June 18, 2025, at 11:01 a.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated Resident 18 had an order for O2 at 3 LPM via NC or face mask continuously. She stated the licensed nurses on the night shift were responsible for changing the NC. She stated the facility practice was to change the respiratory equipment every Sunday night. She also stated the respiratory equipment should be changed at least every seven days, labeled, dated, and stored in a plastic bag when not in use for infection control. On June 18, 2025, at 11:25 a.m., the DON was interviewed. She stated the facility practice was to change the O2 cannula every Sunday night by the charge nurses. She also stated when not in use, the O2 cannula should be stored in a plastic bag, labeled and dated, for infection control. Resident 18's record was reviewed. Resident 18 was admitted to the facility on [DATE], with diagnoses which included pulmonary edema (a condition with excess fluid in the lungs) and pleural effusion (a build up of fluid between the lungs and the chest). Resident 18's Brief Interview of Mental Status (BIMS - an assessment tool), dated May 28, 2025, indicated a score of 14 (cognitively intact). The Physician's Order, dated June 16, 2025, indicated, .Change nasal cannula or face mask and tubing q (every) week on Sundays. Date nasal canula or face mask and tubing when changed. Every night shift every Sunday . The facility policy and procedure titled Oxygen Therapy, reviewed January 6, 2025, indicated, .The cannula should be dated with date set-up and/or changed .A clean bag will be placed at the patient's bedside for cannula storage when not in use. The bag will be labeled with the patient's name and date of set-up/change . Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for 3 out of 65 sampled residents when: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555884	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Heights Healthcare Center, LLC	8951 Granite Hill Drive Riverside, CA 92509

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. For Residents 28 and 52, nursing staff failed to properly clean a shared glucometer (blood glucose meter to measure and display the amount of sugar [glucose] in your blood) according to the disposable wipe manufacturer's specified contact time (the time the resident equipment was to be in contact with the disposable wipes to kill micro-organisms); and 2. For Resident 18, the nasal cannula tubing (NC - a tube used to deliver oxygen through the nose) was not changed every seven days and stored in a sanitary plastic bag as per facility policy and procedure. These failures had the potential for Residents 18, 28, and 52 to be exposed to bacterial cross contamination and the development of infection. Findings: 1. During an observation on June 18, 2025, at 11:25 a.m., Licensed Vocational Nurse (LVN) 2 was observed using a shared glucometer to measure Resident 28's concentration of blood glucose. LVN 2 was observed wiping the glucometer with a Sani-Cloth disposable wipe and did not disinfect the glucometer according to the manufacturer specified contact time. During another observation on June 18, 2025, at 11:44 a.m., LVN 2 was observed using the same shared glucometer to measure Resident 52's concentration of blood glucose. LVN 2 was observed wiping the glucometer with a Sani-Cloth disposable wipe and did not disinfect the glucometer according to the manufacturer specified contact time. During an interview on June 18, 2025, at 12 p.m., LVN 2 stated nursing staff needed to wipe all shared resident care equipment, such as glucometers, with Sani-Cloth disposable wipe to disinfect after each use and let the glucometer air dry for two (2) minutes. Additionally, LVN 2 stated she did knot know what contact time meant. LVN read the manufacturer's instructions on the disposable wipe label and acknowledged the instructions indicated, Allow surface to remain wet for two (2) minutes. During an interview on June 18, 2025, at 12:08 p.m. with the Infection Preventionist (IP), the IP stated nursing staff were expected to clean and disinfect all shared resident care equipment after use and before the next resident using Sani-Cloth disposable wipes. The IP stated nursing staff needed to wipe the equipment, put it down, and wait to air dry for two (2) minutes before using on the next resident. The IP stated contact time meant the time required for the equipment become disinfected according to the manufacturer's instructions. The IP read the manufacturer's instructions on the disposable wipe label and acknowledged the instructions indicated, Allow surface to remain wet for two (2) minutes. The IP acknowledged nursing staff should have been instructed to keep the surface wet for two (2) minutes to achieve contact time when disinfecting shared resident care equipment, such as glucometers, according to the manufacturer's instructions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on June 18, 2025, at 12:30 p.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to clean and disinfect all shared resident care equipment between every resident after each use and to follow the Sani-Cloth manufacturer's instructions for contact time to achieve proper kill time of organisms. The DON read the manufacturer's instructions on the disposable wipe label and acknowledged the instructions indicated, Allow surface to remain wet for two (2) minutes. The DON acknowledged nursing staff should have been instructed to keep the surface wet for two (2) minutes to achieve contact time when disinfecting shared resident care equipment, such as glucometers, according to the manufacturer's instructions. During a follow-up interview on June 19, 2025, at 1:06 p.m., the DON stated it was important to follow the disposable wipe manufacturer's instructions for contact time when disinfecting shared resident care equipment to ensure the wipe effectively killed organisms to prevent cross contamination. During a review of the facility's policy and procedure (P&P) titled, Blood glucose monitoring with insulin coverage, dated January 16, 2025, the P&P indicated, Procedure .sanitize and disinfect the glucometers machine following manufacturer's recommendations. During a review of the manufacturer's instructions for contact time for the Sani-Wipes provided by the facility, the manufacturer's instructions indicated, Contact time .thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry.