STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056162	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Riverside	8171 Magnolia Avenue Riverside, CA 92504

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to assess for self-administration of medication for 1 (Resident #93) of 1 sampled resident that expressed a desire to self-administer medications. Findings included: A facility policy titled, Resident Self-Administration of Medication, dated 12/19/2022, indicated, It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. An Admission Record revealed the facility admitted Resident #93 on 11/05/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of atelectasis (complete or partial collapse of a lung). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/09/2024, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS also revealed that Resident #93 had adequate vision with the use of corrective lenses and was able to be understood and able to understand others. The MDS indicated Resident #93 had no functional limitation in range of motion in their upper extremities. Resident #93's care plan included a focus area, initiated on 11/18/2024, that indicated the resident was at risk for altered respiratory status or difficulty breathing related to atelectasis. An intervention dated 11/18/2024 directed staff to encourage Resident #93 to clear their own secretions with effective coughing and to suction the resident if the secretions could not be cleared. During an interview with Resident #93 on 12/16/2024 at 2:03 PM, a bottle of Robitussin (an expectorant that helps loosen congestion in the chest and throat) was seen sitting on the nightstand to the right of the resident. Resident #93 stated a family member brought the medication to them. Resident #93 stated staff had to know they had the medication, since it was sitting on top of their nightstand in the open. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93's Medication Review Report, reflecting orders effective on or after 12/17/2024, revealed the resident had no order for the use of Robitussin. There were also no orders indicating the resident was able to self-administer any of their medications. On 12/17/2024 at 4:51 PM, the Robitussin remained on Resident #93's bedside table. Resident #93, the resident's roommate, and visitors were in the room. The privacy curtain was pulled between the beds, and only Resident #93 or any person that went on the resident's side of the room were able to visualize the medication. Certified Nursing Assistant (CNA) #1 was interviewed on 12/18/2024 at 1:35 PM. CNA #1 stated if she saw any type of medications in a resident's room she would leave the medication in the room, since she had been taught not to move resident's property and would report the medication to the nurse. CNA #1 stated she was caring for Resident #93 that day (12/18/2024) and had not seen any medication in the resident's room. An observation on 12/19/2024 at 10:03 AM revealed Resident #93 was lying in bed with the bottle of Robitussin clearly visible on their nightstand. Resident #93 stated their family member heard them cough and brought the medication into the facility a few weeks prior. Resident #93 said they had taken a couple of drinks of the medication and that had been all. The resident said they would like to self-administer the Robitussin but stated they had not been assessed for self-administration. Resident #93 also said staff had not spoken to them about keeping the medication stored in their drawer out of sight. CNA #2 was interviewed on 12/19/2024 at 10:27 AM. CNA #2 stated if he saw medications at a resident's bedside he would tell the nurses. CNA #2 stated he had not seen cough medication at Resident #93's bedside, although he had provided care to the resident. Licensed Vocational Nurse (LVN) #3 was interviewed on 12/19/2024 at 10:35 AM. She stated that 12/19/2024 was the first time in two weeks she had cared for Resident #93. LVN #3 stated that prior to a resident self-administering medications, the physician was notified and an order for self-administration was received. LVN #3 stated the facility completed an assessment to determine if a resident was able to self-administer medications. LVN #3 was unaware of any resident that was able to self-administer medications and stated she had not seen medications at residents' bedsides. LVN #3 stated she was not sure if Resident #93 had been assessed for self-administration of medications. LVN #3 then checked Resident #93's room and found the bottle of Robitussin at the resident's bedside. LVN #3 stated that since Resident #93 had no order for the Robitussin, the Robitussin should not have been at the resident's bedside. The Director of Nursing (DON) was interviewed on 12/19/2024 at 12:43 PM and stated there were no residents in the building that had been approved for self-administration of medications. The DON stated if a resident wanted to self-administer medications, an order was obtained from the physician, the interdisciplinary team assessed the resident to make sure the resident was capable of self-administration, and if the medication was kept at bedside, the physician's order had to include, May keep at bedside. The DON stated he would have expected to be notified when the medication was found at Resident #93's bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 12/19/2024 at 2:57 PM. The Administrator stated he expected residents to be assessed for self-administration of medications prior to self-administration, per the facility policy.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 46659 Based on interview, record review, and facility policy review, the facility failed to submit a new Preadmission Screening and Resident Review (PASARR) following a newly diagnosed mental disorder for 1 (Resident #45) of 2 sampled residents reviewed for PASARR requirements. Findings included: A facility policy titled, Resident Assessment-Coordination with PASARR Program, revised 12/18/2023, indicated, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy specified, 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review. An Admission Record revealed the facility admitted Resident #45 on 10/14/2022. According to the Admission Record, the resident had a medical history that included diagnoses of unspecified depression (onset date 12/08/2022) and depressive-type schizoaffective disorder (onset date 12/22/2022). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/26/2022, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. According to the MDS, at the time of the assessment, the resident did not have any active psychiatric or mood disorders. A quarterly MDS, with an ARD of 01/26/2023, revealed Resident #45 had active psychiatric diagnoses at the time of the assessment, including depression and schizophrenia. Resident #45's PASARR Level I screening, dated 10/21/2022, revealed the screening type was an Initial Preadmission Screening (PAS). The question regarding whether the resident had a diagnosed mental disorder, such as Depression, Anxiety, Panic, Schizophrenia/Schizoaffective Disorder, Psychotic, Delusional, and/or Mood Disorder was answered No. The Level I screening was Negative, and a Level II evaluation was not required. Resident #45's medical record revealed no evidence an additional PASARR Level I screening was completed after the resident was diagnosed with depression and schizoaffective disorder in 12/2022. During an interview on 12/19/2024 at 12:58 PM, the Director of Nursing (DON) said that if a resident was diagnosed with a new mental disorder, a new PASARR should be completed. The DON confirmed Resident #45 was diagnosed with two new mental health diagnoses in 12/2022, so a new PASARR should have been completed. During an interview on 12/19/2024 at 2:49 PM, The Administrator stated he expected staff to follow the facility's policy for the PASARR process.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 22445 Based on interview, record review, and facility policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) Level I screening accurately reflected the presence of diagnosed mental disorders for 1 (Resident #23) of 2 sampled residents reviewed for PASARR requirements. Findings included: A facility policy titled, Resident Assessment-Coordination with PASARR Program, revised 12/18/2023, indicated, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The policy specified, 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I- initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. An Admission Record revealed the facility admitted Resident #23 on 10/08/2024. According to the Admission Record, Resident #23 had a medical history that included diagnoses of unspecified bipolar disorder and unspecified depression, both with an onset date of 10/08/2024. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/12/2024, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #23 had active psychiatric and mood disorders, including bipolar disorder and depression. Resident #23's PASARR Level I screening, completed by a local hospital on 10/08/2024, revealed the screening type was an Initial Preadmission Screening (PAS). The question regarding whether the resident had a diagnosed mental disorder, such as Depression, Anxiety, Panic, Schizophrenia/Schizoaffective Disorder, Psychotic, Delusional, and/or Mood Disorder was answered No. The resident's diagnoses of bipolar disorder and depression were not reflected. As a result, the Level I screening was Negative, and a Level II evaluation was not required. MDS Coordinator Licensed Vocational Nurse (LVN) #17 was interviewed on 12/19/2024 at 11:27 AM. MDS Coordinator LVN #17 stated she recently became involved in the PASARR process about a month prior and explained her responsibilities included uploading PASARRs to medical records and reviewing to ensure a Level II evaluation was not needed. She stated it was the responsibility of the Director of Nursing (DON) to make sure the information on the PASARR Level I screenings was accurate. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 12/19/2024 at 12:57 PM. The DON stated that when a resident was admitted to the facility with a PASARR completed by a hospital, either the MDS staff or the DON checked the PASARR for accuracy, including checking to make sure all mental health diagnoses were included. The DON stated an accurate PASARR was important for billing purposes and to provide better care for the residents. The DON stated if the Level I screening was not accurate, then a Level II evaluation would not be completed. The DON reviewed Resident #23's Level I screening and the resident's diagnoses list and stated Resident #23's Level I screening was not accurate. The DON stated the person that reviewed the PASARR should have caught the error and completed a new Level I PASARR for Resident #23. The Administrator was interviewed on 12/19/2024 at 2:54 PM and stated he expected staff to follow the facility policy for PASARRs.

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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. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff provided needed assistance with activities of daily living (ADLs) for 1 (Resident #85) of 1 sampled resident reviewed for ADLs. Specifically, staff failed to assist Resident #85 with facial hair grooming and nail care. Findings included: A facility policy titled, Grooming a Resident's Facial Hair, dated 12/19/2022, indicated, It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice. A facility policy titled, Nail Care, dated 12/19/2022, revealed, 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. An Admission Record revealed the facility admitted Resident #85 on 10/09/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following a cerebral infarction (stroke) affecting the left, non-dominant side. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/31/2024, indicated Resident #85 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #85 had a functional limitation in range of motion on one side of their upper extremities. The MDS revealed the resident required substantial/maximal assistance from staff to complete personal hygiene, including shaving. On 12/16/2024 at 2:11 PM, Resident #85 was observed with long toenails, fingernails, and facial hair. Resident #85 commented that their toenails were pretty bad. During an observation on 12/17/2024 at 3:40 PM, Resident #85 was lying in bed. The resident remained unshaven, and their fingernails extended a quarter-inch to a half-inch beyond the tips of the fingers, with their toenails extending a quarter-inch to a half-inch beyond the tips of the toes. Certified Nursing Assistant (CNA) #1 was interviewed on 12/18/2024 at 1:37 PM. CNA #1 stated cleaning and clipping of residents' fingernails was the responsibility of the CNAs if the resident was not diabetic, and if the resident was diabetic, nurses were responsible. CNA #1 stated shaving residents was the responsibility of the CNAs, but if the resident was easily cut then the nurse on the hall was responsible. CNA #1 stated residents were shaven on request or as needed. During an observation on 12/18/2024 at 1:51 PM, Resident #85 was lying in bed. The resident's fingernails were clean but long, and their toenails remained long. The resident's facial hair appeared to be a half-inch to an inch in length. Resident #85 stated they needed a shave, but they were unable to shave alone. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #4 was interviewed on 12/18/2024 at 2:04 PM. CNA #4 stated the CNAs were responsible for shaving residents on scheduled shower days and as needed. He stated cleaning and trimming fingernails were the responsibility of the CNAs, and that was done as needed. CNA #4 stated if any resident refused care, he reported the refusal to the nurse and added that Resident #85 had not refused care. CNA #4 stated Resident #85's showers were scheduled for Mondays and Thursdays. CNA #4 said he had taken care of Resident #85 on Monday, 12/16/2024. CNA #4 confirmed he had showered the resident on 12/16/2024 but had not shaved the resident, because he did not have enough time. CNA #4 observed the resident and confirmed the resident needed a shave and was unable to shave alone. He acknowledged the resident's toenails needed to be trimmed and stated he had not reported the long toenails to anyone. CNA #4 also stated the resident's fingernails were too long and unclean, but he had not had time to clean and clip the resident's nails. During a concurrent observation and interview on 12/18/2024 at 2:11 PM, Licensed Vocational Nurse (LVN) #5 observed Resident #85's toenails. LVN #5 asked the resident if their toenails hurt, and the resident reported their left great toenail hurt. A large amount of dark tissue was observed under the resident's left great toenail. The resident's right great toenail extended a half-inch beyond the tip of the toe. LVN #5 confirmed the resident's nails needed to be cleaned and trimmed, and the resident's facial hair was too long. The Director of Nursing (DON) was interviewed on 12/18/2024 at 3:20 PM. He stated he expected residents to be groomed and stated it was not acceptable for a CNA to say they were too busy to provide care. He stated he expected staff that did not complete tasks to tell the next shift or to notify the charge nurse, Assistant Director of Nursing (ADON), or DON they needed help. The DON stated residents were expected to be shaven when their facial hair was long. The DON further stated the CNAs were responsible for cleaning and trimming residents' nails and shaving residents. The Administrator was interviewed on 12/19/2024 at 2:59 PM and stated he expected residents to be shaven and receive nail care as needed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to provide tube feeding formula as ordered to 1 (Resident #85) of 3 sampled residents reviewed for nutrition. Specifically, Resident #85's order directed staff to provide Isosource 1.5 (a type of tube feeding formula that provided 1.5 calories per milliliter) to the resident at a rate of 60 milliliters (mL) per hour for 16 hours per day, but staff provided Fibersource HN (a type of tube feeding formula that provided 1.2 calories per mL) instead, which created a potential for weight loss and for the resident's nutritional needs to not be met. Findings included: A facility policy titled, Appropriate Use of Feeding Tubes, revised 12/19/2022, indicated, It is a policy of this facility to ensure that a resident maintains acceptable parameters of nutritional and hydration status. An Admission Record revealed the facility originally admitted Resident #85 on 10/09/2024 and most recently admitted the resident on 12/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) following a cerebral infarction (stroke) and gastrostomy status. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/31/2024, revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had complaints of difficulty or pain with swallowing and received nutrition by way of a feeding tube. According to the MDS, Resident #85 received 51% or more of their total calories through a feeding tube. Resident #85's care plan included a focus area, initiated on 10/10/2024, that indicated the resident had a nutritional problem or a potential nutritional problem and received food by mouth as well as nutrition by way of a feeding tube. An intervention dated 11/01/2024 directed staff to utilize the resident's feeding tube as ordered. Resident #85's Medication Review Report, reflecting active orders on or after 12/17/2024, revealed an order started on 12/16/2024 for continuous tube feeding with Isosource 1.5 at a rate of 60 mL per hour for 16 hours per day. The order directed staff to start the resident's tube feeding formula at 2:00 PM each day and to turn it off at 6:00 AM or when the tube feeding formula had infused. The Medication Review Report also revealed on order started on 12/04/2024 for a no added salt, bite-sized diet for breakfast, lunch, and dinner. An observation on 12/17/2024 at 3:40 PM revealed Resident #85 was receiving Fibersource HN by way of their feeding tube at a rate of 60 mL per hour. The bag of Fibersource HN formula was labeled with a start date and time of 12/17/2024 at 2:00 PM. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 12/18/2024 at 2:17 PM revealed Licensed Vocational Nurse (LVN) #5 was hanging a bag of tube feeding formula for Resident #85. LVN #5 initiated the resident's tube feeding using Fibersource HN formula. LVN #5 stated Resident #85's order was for Jevity 1.2 (a type of tube feeding formula that provided 1.2 calories per mL), but the Fibersource HN was a replacement formula and could be interchanged. Resident #85's 12/2024 Medication Administration Record (MAR) revealed that during the 7:00 AM to 3:00 PM shift on 12/17/2024 and 12/18/2024, LVN #5 signed as having initiated the resident's Isosource 1.5 tube feeding as ordered. The Registered Dietitian (RD) was interviewed by phone on 12/18/2024 at 3:00 PM. The RD stated she changed Resident #85's tube feeding formula on 12/16/2024 due to the resident's oral intake of food being 60 percent (%) to 80 % of meals. The RD stated the change in formula was to prevent weight loss as the resident transitioned to an oral diet. The RD stated the resident's ordered tube feeding formula was Isosource 1.5 at 60 mL per hour for 16 hours each day, which provided the resident with 1440 calories. The RD stated substituting Fibersource HN was not a comparable exchange, since the resident would only receive 1152 calories in 16 hours for a difference of approximately 300 calories per 16 hours. She stated if the Isosource 1.5, which had been ordered, or Jevity 1.5, which was a comparable exchange for the Isosource 1.5, was not available in the facility, she expected staff to call her for directions. The RD stated she had received no calls from the facility regarding Resident #85's tube feeding formula. The Director of Nursing (DON) was interviewed on 12/18/2024 at 3:20 PM. He stated if the ordered formula for Resident #85 was not available, he expected staff to call the RD and the physician for directions. He stated there was also a sheet in the tube feeding formula closet directing staff to what formulas were comparable and could be exchanged. During the interview, the DON walked to the resident's room and verified that Fibersource HN was infusing at 60 mL per hour. The DON then reviewed the resident's physician's order and verified the order was for Isosource 1.5. LVN #5 was interviewed on 12/18/2024 at 3:30 PM and stated she had exchanged the resident's formula based on the formula exchange sheet hanging in the tube feeding formula closet. During the interview, LVN #5, the DON, and the surveyor reviewed the exchange sheet, and LVN #5 again stated Resident #85 received Jevity 1.2, so the Fibersource HN was an acceptable exchange. However, LVN #5 confirmed she had not reviewed the resident's orders and was unaware the resident's tube feeding formula was changed on 12/16/2024. LVN #5 stated she went by what was used the day before and based the formula selection on the empty bag hanging on the resident's tube feeding pole. The DON was interviewed on 12/19/2024 at 1:36 PM and stated he expected the nurses to follow physician's orders for tube feeding formulas. The Administrator was interviewed on 12/19/2024 at 2:59 PM and stated he expected staff to follow physician's orders when choosing formulas for tube-fed residents.

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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. 46659 Based on observation, interview, and facility policy review, the facility failed to properly store a nebulizer mask between uses for 1 (Resident #7) of 1 sampled resident reviewed for respiratory care. Findings included: A facility policy titled, Nebulizer Therapy, revised 02/23/2024, revealed the section titled, Care of Equipment specified, 1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble parts after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 5. Shake off excess water. 6. Air dry on absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a storage bag. An Admission Record revealed the facility admitted Resident #7 on 11/10/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of pneumonia. Resident #7's care plan included a focus area, initiated on 11/26/2024, that indicated the resident had shortness of breath related to a cough. An intervention dated 11/26/2024 directed staff to administer DuoNeb (ipratropium-albuterol; a nebulizer treatment) as ordered. Resident #7's Medication Review Report, reflecting orders effective on or after 12/19/2024, revealed an order dated 11/26/2024 for ipratropium-albuterol inhalation solution 0.5 milligrams (mg)-2.5 mg per 3 milliliter (mL) vial every four hours as needed for cough and shortness of breath. Resident #7's 12/2024 Medication Administration Record (MAR) revealed documentation that indicated the resident received their as needed ipratropium-albuterol treatment on 12/16/2024 at 12:40 AM and 10:36 AM and 12/17/2024 at 12:30 AM and 4:57 AM. An observation on 12/16/2024 at 11:27 AM revealed Resident #7's nebulizer mask was not stored in a bag. An observation on 12/17/2024 at 12:08 PM revealed Resident #7's nebulizer mask was lying on top of the resident's dresser, not stored in a bag. During an interview on 12/17/2024 at 1:05 PM, Licensed Vocational Nurse (LVN) #3 said that Resident #7 received as needed nebulizer treatments, and the nebulizer mask should be stored in a bag when not in use. During an interview on 12/19/2024 at 12:58 PM, the Director of Nursing (DON) said nebulizer masks should be cleaned and stored in a bag when not in use. During an interview on 12/19/2024 at 2:49 PM, the Administrator said he expected staff to follow the facility's policy regarding cleaning and storage of nebulizer masks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056162	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Extended Care Hospital of Riverside	8171 Magnolia Avenue Riverside, CA 92504

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46194 Based on observation, interview, record review, and facility policy review, the facility failed to ensure pain was treated after a request for an ordered as needed (PRN) pain medication for 1 (Resident #210) of 1 sampled resident reviewed for pain management. Findings included: A facility policy titled, Pain Management, dated 12/19/2022, indicated, The facility must ensure that pain management is provide to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The policy specified, 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. b. Evaluate the resident for pain and the cause(s) upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs. c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. An Admission Record indicated the facility admitted Resident #210 on 12/11/2024. According to the Admission Record, the resident had a medical history that included diagnoses of low back pain, personal history of malignant neoplasm of the breast, and acute kidney failure. A Baseline Care Plan and Summary, with an effective date of 12/11/2024, indicated Resident #210 had the presence of pain. Resident #210's Medication Review Report, reflecting orders effective on or after 12/19/2024, revealed an order dated 12/11/2024 for the resident to receive dialysis every Monday, Wednesday, and Friday. The Medication Review Report also revealed orders dated 12/11/2024 for Tylenol 650 milligrams (mg) by mouth (PO) every 6 hours PRN for pain and Norco (hydrocodone-acetaminophen) 10-325 mg PO every 6 hours PRN for moderate to severe pain. During an interview on 12/16/2024 at 11:04 AM, Resident #210 stated that when they were just sitting in bed and not doing anything, their pain was at a 7, on a scale from 0 to 10. The resident stated they were prescribed hydrocodone for pain and would like to get their pain medication before they went to dialysis. On 12/16/2024 at 11:07 AM, Resident #210 was observed to request pain medication from Certified Nursing Assistant (CNA) #6. Resident #210's Medications Administration Record for 12/2024 revealed no documented evidence that the resident received their PRN Tylenol or Norco on 12/16/2024, per the resident's request. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/2024 at 11:55 AM, CNA #6 stated that when Resident #210 asked for their pain medication, he went straight to Licensed Vocational Nurse (LVN) #7 and told him the resident needed their hydrocodone. On 12/17/2024 at 10:29 AM, Licensed Vocational Nurse (LVN) #7 stated he could not remember if CNA #6 told him Resident #210 needed a pain pill on 12/16/2024. LVN #7 stated he did not give the resident a pain pill before they went to dialysis. On 12/19/2024 at 9:29 AM, the Administrator stated the resident's pain medication should have been given if the resident complained of pain.

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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. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff wore all required personal protective equipment (PPE) during the provision of care for residents on enhanced barrier precautions (EBP). This deficient practice affected 1 (Resident #18) of 4 residents observed during the medication administration task and 1 (Resident #5) of 4 residents sampled as part of the infection control task. Findings included: A facility policy titled, Enhanced Barrier Precautions, revised 06/17/2024, indicated, 'Enhanced Barrier Precautions' refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The policy specified, b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and indicated High-contact resident care activities included a. Dressing b. Bathing/Shower, d. Providing hygiene e. Changing linens and g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. 1. An Admission Record revealed the facility most recently admitted Resident #18 on 05/05/2023. According to the Admission Record, the resident had a medical history that included diagnoses of dysphagia (difficulty swallowing) following a cerebral infarction (stroke) and gastrostomy status. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/19/2024, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. According to the MDS, the resident utilized a feeding tube. Resident #18's care plan included a focus area, initiated on 07/08/2024, that indicated the resident was on EBP related to the use of a gastrostomy tube and a history of extended-spectrum beta-lactamase (ESBL; a type of enzyme causing some antibiotics to be ineffective in treating bacterial infections). The care plan indicated the goal was to prevent/reduce the transmission of multi-drug resistant organisms (MDROs) through the use of gowns and gloves while caring for residents at high risk for MDRO transmission at the point of care during specific activities with the greatest risk for MDRO contamination of health care personnel's hands, clothes, and the environment. The care plan directed staff to apply EBP to prevent the spread of infections for specific care activities, including caring for devices and giving medical treatments. Resident #18's Medication Review Report, reflecting orders effective on or after 12/17/2024, revealed an order started on 05/24/2024 for EBP due to the use of a gastrostomy tube and history of ESBL. During an observation on 12/19/2024 at 8:00 AM, Licensed Vocational Nurse (LVN) #9 checked Resident #18's blood pressure and oxygen saturation and administered medications by way of the resident's feeding tube while wearing gloves but no gown. On 12/19/2024 at 10:56 AM, LVN #9 stated she had not donned a gown when checking Resident #18's vital signs or administering the resident's medication by way of their gastrostomy tube because she did not know she should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 12/19/2024 at 1:38 PM and stated EBP was to be implemented when providing care to residents that had wounds, gastrostomy tubes, central lines, or catheters. The DON stated he expected nurses to wear a gown and gloves when administering medications to residents with a gastrostomy tube. 46659 2. An Admission Record revealed the facility admitted Resident #5 on 12/14/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of colostomy malfunction. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/06/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had an ostomy. Resident #5's care plan included a focus area, initiated 10/08/2024, that indicated the resident was on EBP related to a history of extended-spectrum beta-lactamase (ESBL; a type of enzyme causing some antibiotics to be ineffective in treating bacterial infections). The care plan indicated the goal was to prevent/reduce the transmission of multi-drug resistant organisms (MDROs) through the use of gowns and gloves while caring for residents at high risk for MDRO transmission at the point of care during specific activities with the greatest risk for MDRO contamination of health care personnel's hands, clothes, and the environment. The care plan directed staff to apply EBP to prevent the spread of infections for specific care activities, including caring for devices, giving medical treatments, during morning and evening care, and when cleaning and disinfecting the environment. Resident #5's Medication Review Report, reflecting orders effective on or after 12/19/2024, revealed an order started on 10/08/2024 for EBP due to a history of ESBL. During a concurrent observation and interview on 12/16/2024 at 10:52 AM, Certified Nursing Assistant (CNA) #10 changed Resident #5's bed linens while wearing a mask and gloves but no gown. At this time, CNA #10 stated she had also provided the resident a bed bath while wearing a mask and gloves but no gown. CNA #10 then stated that because Resident #5 was on EBP, she should have worn a gown and gloves. During an interview on 12/19/2024 at 12:58 PM, the Director of Nursing (DON) said he expected the staff to wear the appropriate PPE when providing care to residents on EBP.