STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555017	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERWALK POST ACUTE	**4000 HARRISON STREET RIVERSIDE, CA 92503**

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 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff verified, documented, and timely returned personal belongings for one of three sampled residents (Resident A). This failure increased the potential for the resident's belongings and financial information to be lost, stolen, or used without her consent. Findings: On March 13, 2020, the Department received a complaint with multiple allegations of financial abuse regarding Resident A, including a staff member went to the resident's house to get some of the resident's belongings, and the belongings were not returned to the resident when she was discharged . On May 15, 2020, at 9:55 a.m., an unannounced visit was made to the facility for the investigation of the complaint. On May 15, 2020, beginning at 10:50 a.m., Resident A's record was reviewed and indicated Resident A was admitted to the facility January 9, 2020, with [DIAGNOSES REDACTED]. The record indicated the resident was self-responsible, and had a BIMS score of 08 (Brief Interview Mental Status-standardized assessment of cognitive ability with scores of 0 lowest and 15 highest). The record indicated Resident A's sister was her emergency contact person, and the resident was discharged to a room and board home (provides rooms for rent) on March 2, 2020. The Nurse's Notes, dated February 26, 2020, indicated Resident A left the facility with a Social Services staff (SS 1) and a Certified Nursing Assistant (CNA) and returned the same day. The Social Services Notes, dated March 9, 2020, at 10:58, (one week after the resident was discharged) indicated Resident A's wallet, financial bills, house keys, cell phone, and charger were kept at the facility after discharge when SS 1 was asked to hold the resident's belongings. There was no documented indication that SS 1 explained to the resident the standard practice/policy that all valuables and belongings were to go with the resident when they were discharged , and no documented indication how SS 1 planned to return the belongings to the resident. There was no documented indication that SS 1 attempted to contact the resident's sister during her stay regarding her belongings. On May 15, 2020, at 11:15 a.m., the Administrator (ADM) was interviewed, and verified SS 1 took Resident A to her home to get the resident's wallet and identification. On May 18, 2020, at 10:46 a.m., SS 1 was interviewed by telephone and stated she remembered Resident A. SS 1 verified that she took Resident A to the resident's house and the bank. SS 1 stated the resident wanted to get her purse, and pay a facility bill. SS 1 stated when they went to the bank, the lady at the bank gave Resident A three or four checks, and Resident A put them in her wallet. SS 1 stated when Resident A was discharged , the resident left her belongings at the facility, and asked SS 1 to follow her to the room and board to greet the owner. SS 1 stated she followed the transport driver to the room and board, and greeted the owner. When asked why she did not return all of Resident A's belongings at the time the resident was discharged , SS 1 stated the transport company was in a hurry. When asked if she attempted to contact the resident's family to assist the resident with her belongings, SS 1 stated the resident had no family, and she thought she documented that. On May 18, 2020, at 1:26 p.m., Resident A's record was further reviewed. The Nurse's Discharge Notes, dated March 2, 2020, at 4:28 p.m., indicated Resident A was discharged to a board and care facility with all belongings. Resident A's Personal Property Inventory form, (used to document resident's personal belongings brought in to the facility during their stay, and to document all belongings were accounted for and returned at the time of discharge), dated January 9, 2020, was reviewed, and had no documented indication of Resident A's wallet, keys, cell phone, or financial papers/bills that were brought to the facility by the resident and SS 1. On May 18, 2020, at 2:25 p.m., the ADM was interviewed by telephone and stated the Personal Property Inventory (resident belongings list) should be updated when belongings were brought in to the facility. On May 21, 2020, at 10 a.m., the room and board owner (RBO) was interviewed by telephone and stated Resident A was asking and looking for her ID and wallet after she arrived at the room and board. The RBO stated Resident A complained about SS 1, and the RBO did not know why SS 1 kept Resident A's belongings, it was not protocol. The facility policy and procedure titled Release of a Resident's Personal Belongings last revised March 2017, was reviewed and indicated, .Our facility protects the personal belongongs of a resident .personal belongings of a resident .discharged from our facility will be released to the resident or authorized representative .Individuals receiving the resident's personal belongings will be required to sign a release for the items .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.