STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055084	A. Building B. Wing	03/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbank Post-Acute	2649 Topeka Street Riverbank, CA 95367

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 51749 Based on interview and record review, the facility failed to notify the physician that 1 (Resident #6) of 1 sampled resident reviewed for dialysis did not receive their ordered medications when they were out of the facility at dialysis three days each week. Findings included: An Admission Record revealed the facility admitted Resident #6 on 04/06/2024. According to the Admission Record, the resident had a medical history to include diagnoses of acute pulmonary embolism, dependence of renal dialysis, major depressive disorder, hypotension, chronic embolism and thrombosis of left lower extremity, and chronic kidney disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/30/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #6's Care Plan Report included a focus area initiated 12/29/2023, that indicated the resident needed dialysis related to a diagnosis of end stage renal disease. Interventions indicated the resident's dialysis days were Mondays, Wednesdays, and Fridays, with a chair time of 6:30 AM on each day. Resident #6's Medication Administration Record [MAR] for the timeframe 03/01/2025 - 03/31/2025, revealed the transcription of the following orders: - an order with a start date of 06/30/2024 and a discontinue date of 03/13/2025, for fluoxetine hydrochloride (HCL) (an antidepressant medication) oral capsule 10 milligram (mg), give one capsule by mouth one time a day for crying spells and irritability. - an order with a start date of 04/07/2024 and a discontinue date of 03/13/2025, for Lasix (a diuretic medication) oral tablet 20 mg, give one tablet by mouth one time a day for pulmonary edema. - an order with a start date of 04/06/2024, for Eliquis (an anticoagulant medication) oral tablet 5 mg, give 5 mg by mouth two times a day for chronic embolism. (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: 055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2025
NAME OF PROVIDER OR SUPPLIER: Riverbank Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 2649 Topeka Street Riverbank, CA 95367	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an order with a start date of 06/20/2024 and a discontinue date of 03/13/2025, for metoprolol tartrate (a blood pressure medication) oral tablet 25 mg, give one tablet by mouth every 12 hours and hold for a systolic blood pressure of less than 100 millimeters of mercury a heart rate less than 60 beats per minute. According to the MAR, there was no evidence to indicate fluoxetine HCL, Lasix, Eliquis, or metoprolol tartrate were administered to the resident on 03/03/2025 (Monday), 03/05/2025 (Wednesday), 03/07/2025 (Friday), 03/10/2025 (Monday), and 03/12/2025 (Wednesday). During an interview on 03/13/2025 at 2:15 PM, Licensed Vocational Nurse (LVN) #7 reviewed Resident #6's MAR for the timeframe 03/01/2025 - 03/31/2025 and stated the resident did not receive those medications (fluoxetine, Lasix, Eliquis, and metoprolol) because the resident was at dialysis. According to LVN #7, this was something the physician should have been notified of. During an interview on 03/13/2025 at 3:52 PM, LVN #2 reviewed Resident #6's MAR for the timeframe 03/01/2025 - 03/31/2025 and stated she notified the physician of the resident missing those medications ((fluoxetine, Lasix, Eliquis, and metoprolol) three times each week, but could not find any documentation to show evidence the physician had been notified. During an interview on 03/14/2025 at 4:00 PM, Medical Doctor #3 stated he would like to be notified when the resident missed medications three times each week. During an interview on 03/14/2025 at 4:14 PM, the Assistant Director of Nursing stated it would be expected of the staff to notify the physician if medications were not administered as ordered. During an interview on 03/15/2025 at 9:45 AM, the Director of Nursing (DON) stated the expectation was that staff notify the physician when a resident missed their medications. Per the DON, the staff should have notified the physician when Resident #6 missed their medications three times each week. During an interview on 03/15/2025 at 9:56 AM, the Administrator stated he deferred all questions related to notification of the physician to nursing. During a follow-up interview on 03/15/2025 at 1:57 PM, the DON stated she was unable to find a policy related to notification of the physician.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 31524 Based on interview, record review, and facility policy review, the facility failed to ensure a new level I preadmission screening and resident review (PASARR) was completed for 2 (Resident #53 and Resident #75) of 2 sampled residents reviewed for PASARR, who remained in the facility after 30 days. Findings included: A facility policy, titled, Admission Criteria, revised 03/2019, indicated, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. 1. An Admission Record indicated the facility admitted Resident #53 on 09/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of borderline personality disorder and bipolar disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/04/2025, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #53's Care Plan Report, included a focus area initiated 01/21/2025, that indicated the resident used psychotropic medications related to anxiety. A typed document from the California Department of Health Care Services dated 09/10/2024, revealed Resident #53's level I screening indicated a level II mental health evaluation was not required. The document indicated, If the Individual [Resident #53] remains in the NF [nursing facility] longer than 30 days, the facility must submit a new Level I Screening as a Resident Review on the 31st day. During an interview on 03/14/2025 at 4:09 PM, the MDS Coordinator stated Resident #53 was a 30-day hospital exempt resident but had been in the facility for more than 30 days. Per the MDS Coordinator, another level I PASARR should have been completed prior to the resident being in the facility for a month, but it was an oversight on her part because it was not done. During an interview on 03/15/2025 at 9:38 AM, the Director of Nursing (DON) stated if a resident was going to be in the facility longer than 30 days, the facility needed to do another level I PASARR. The DON stated Resident #53 should have had a second level I PASARR completed because they were in the facility longer than 30 days. During an interview on 03/15/2025 at 9:54 AM, the Administrator stated he was not really involved in the PASARR process, was not sure of the process, and deferred to nursing. 51749 2. An Admission Record revealed the facility admitted Resident #75 on 08/15/2024. According to the Admission Record, the resident had a medical history that included diagnoses of post-traumatic stress disorder, bipolar disorder, and anxiety disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/20/2025, revealed Resident #75 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #75's Care Plan Report, included a focus area initiated 09/11/2024, that indicated the resident used psychotropic medications related to diagnoses of depression and bipolar disorder. A typed document from the California Department of Health Care Services dated 08/15/2024, revealed Resident #75's level I screening indicated a level II mental health evaluation was not required. The document indicated, If the Individual [Resident #53] remains in the NF [nursing facility] longer than 30 days, the facility must submit a new Level I Screening as a Resident Review on the 31st day. During an interview on 03/13/2025 at 2:49 PM, the MDS Coordinator stated another level I screening should have been done for Resident #75 on the resident's 31st day of admission to the facility. During a follow-up interview on 03/13/2025 at 3:50 PM, the MDS Coordinator stated another level I screening for Resident #75 was not done on the 31st day of the resident's admission to the facility as it was an oversight. During an interview on 03/15/2025 at 9:38 AM, the Director of Nursing (DON) stated if a resident was going to be in the facility longer than 30 days, the facility needed to do another level I PASARR. The DON stated Resident #53 should have had a second level I PASARR completed because they were in the facility longer than 30 days. During an interview on 03/15/2025 at 9:54 AM, the Administrator stated he was not really involved in the PASARR process, was not sure of the process, and deferred to nursing.

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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 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. 52066 Based on interview, record review, and facility policy review, the facility failed to ensure a resident's care plan reflected the resident's refusal to sign the smoking policy and interventions for staff to obtain a cigarette lighter from the resident for 1 (Resident #37) of 1 sampled resident reviewed for smoking. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised 03/2022, 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. The policy specified, 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS [Minimum Data Set] assessment. A facility policy titled, Smoking Policy- Residents, revised 08/2022, revealed, 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. An Admission Record revealed the facility admitted Resident #37 on 12/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, delirium due to known physiological condition, and nicotine dependence. An Admission Nursing Assessment, dated 12/12/2024, revealed Resident #37 was a current smoker and the assessment directed staff to complete a smoking assessment. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #37's Care Plan Report included a focus area initiated 12/13/2024, that indicated the resident had a heightened safety risk related to confusion and a personal desire to smoke. Interventions directed staff to apply protective non-flammable apron or cover/barrier during smoking activity (initiated 12/13/2024), keep the resident's cigarettes (initiated 12/13/2024), and keep the resident's lighter(s) (initiated 12/13/2024). Further review of the Care Plan Report included a focus area initiated 01/31/2025, that indicated the resident was noted to smoke used cigarettes found on the ground. Interventions directed staff to post cigarette times in the resident's room (initiated 01/31/2025); explain the risks and benefits to the resident, including the risk of infection (initiated 01/31/2025); and indicated that the resident refused to give staff their lighter (initiated 02/10/2025). Resident #37's Activities-Progress Notes, dated 03/04/2025 at 11:30 AM, revealed an activities staff member spoke with Resident #37 and notified them of the facility's smoking policy. According to the note, the resident refused to sign a copy of the smoking policy that was discussed with them. During an interview on 03/11/2025 at 8:52 AM, the Director of Nursing stated Resident #37 refused to sign the facility's smoking policy. During an interview on 03/11/2025 at 9:13 AM, the Administrator stated he was aware of Resident #37's desire to smoke but not sign the policy. He stated residents were required to sign the smoking policy at admission, but if they refused, a meeting was held with the resident, and they were told that they were not allowed to have a cigarette lighter or cigarettes in their possession. He stated if a resident refused to sign the policy, the information was documented on the smoking policy and the resident's care plan. During an interview on 03/14/2025 at 1:09 PM, the MDS Coordinator stated she had never personally seen Resident #37 with a lighter. She stated interventions should have been added to the care plan to address how staff could obtain the resident's cigarette lighter from the resident. She stated how staff could do that would have been determined by the interdisciplinary team (IDT), which consisted of social services staff, nursing, MDS staff, dietary staff, activities staff, and sometimes administration. She stated that she did not know why there were not additional revisions made to the care plan once it was discovered that the resident had a cigarette lighter.

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure services provided by the nursing facility meet professional standards of quality.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44899

Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for one of 15 sampled residents' (Resident 8) when Resident 8's Albuterol Sulfate inhaler (medication for shortness of breath or wheezing) was not accounted for as active medication and kept by Resident 8 on her overbed table from 3/17/25 to 4/10/25.

This failure had the potential to result in Resident 8 to use the inhaler without proper staff supervision and placed Resident 8 at an increased risk for adverse side effects, such as nervousness, shakiness, fast or irregular heart rate, chest pain, headache, and throat irritation.

Findings:

During a review of Resident 8's Admission Record (AR- a document that

provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/10/25, the AR indicated, Resident 8 was admitted from an acute care hospital on 3/17/25 to the facility, with diagnoses that included

Fracture of Left Tibia (the large bone in the lower leg), Hypertension (high blood pressure), Congestive Heart Failure (CHF- weakness in the heart where fluid accumulates in the lungs), Coronary Artery Bypass Graft (CABG- a surgical procedure used to improve blood flow to the heart), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Anxiety Disorder (a mental health illness characterized by a sudden feeling of panic and fear, restlessness, and uneasiness).

During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 8's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 8 had no cognitive impairment.

During a concurrent observation and interview on 4/10/25 at 1:54 p.m., with Resident 8, inside Resident 8's room, a canister (container, containing the medication) with actuator (a plastic piece that releases the medication) of Albuterol Sulfate inhaler was observed inside a plastic cup on Resident 8's overbed table. Resident 8 stated she uses the Albuterol inhaler daily for her shortness of breath. Resident 8 stated her Albuterol inhaler was always on her overbed table and no staff told her that she cannot keep and use her inhaler from home.

During a concurrent observation and interview on 4/10/25 at 1:56 p.m., with Registered Nurse Supervisor (RNS), inside Resident 8's room. RNS looked at Resident 8's

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overbed table and stated a partially used Albuterol inhaler was inside a clear plastic cup. RNS stated Resident 8's albuterol inhaler was not prescribed by the facility's attending physician and no record of monitoring for potential side effects. RNS stated self-administration of medications requires a physician order and a nursing care plan, and it was not done. During an interview on 4/10/25 at 5:04 p.m., with the Director of Nursing (DON), the DON stated her expectation was for the licensed nurses to query alert Residents about their current medications during admission and to check Residents' room for home medications brought to the facility. The DON stated Resident 8's use of Albuterol inhaler without the facility's knowledge could result to a negative outcome, including drug interactions with her current medications. The DON stated other residents could potentially access and use Resident 8's Albuterol inhaler. During a review of the facility's Policy and Procedure (P&P) titled, Medication and Treatment Orders, dated 7/16, the P&P indicated, . Orders for medications and treatments will be consistent with principles of safe and effective order writing . 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications . During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, undated, the document indicated, . Duties and Responsibilities . Conducts initial and ongoing assessments of residents' health status . Administers medications as prescribed by the healthcare provider . Ensures accurate dosage, proper route, and timely administration . Monitors and records resident's responses to medications . During a review of the facility's document titled, Job Description: Registered Nurse (RN), undated, the document indicated, . Supervises and coordinates the efforts of nursing staff and provides total nursing care for residents . Specific Duties . Monitors nursing care for residents throughout the shift . Obtains medications, supplies, and medical records needed to provide safe, efficient, and therapeutic care to residents on a continuing basis . During a review of a professional reference Food and Drug Administration (FDA), dated 6/2016, the manufacturer's instructions for Albuterol Sulfate indicated, . Indications and Usage . Treatment or prevention of bronchospasm (narrowing of airways, causing wheezing, coughing, and difficulty breathing) . Excessive use may be fatal . Most common adverse reactions . headache, tachycardia (fast heartbeat), pain, dizziness .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 52066 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the safety and well-being for 1 (Resident #37) of 1 sampled resident reviewed for smoking. Specifically, the facility failed to failed to implement further interventions to ensure the safety of the resident and others when the resident continued to smoke after there was indication that the resident agreed to smoking cessation and failed to implement interventions when the resident refused to turn in their lighter. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy was related to State Operations Manual, Appendix PP, 483.25 (d) Accidents, at a scope and severity of J. On 03/12/2025 at 4:38 P.M. the Administrator and the Director of Nursing (DON) were informed of the Immediate Jeopardy situation. Findings included: A facility policy titled, Smoking Policy- Residents, revised 08/2022, revealed, This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. The policy specified, 6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc. [et cetera, and other similar things]); c. desire to quit smoking; and d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 7. The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. 11. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. 12. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. 13. Residents are not permitted to give smoking items to other residents. 14. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Admission Record revealed the facility admitted Resident #37 on 12/12/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dementia, delirium due to known physiological condition, and nicotine dependence. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. An Admission Nursing Assessment, dated 12/12/2024, revealed Resident #37 was a current smoker and the assessment directed staff to complete a smoking assessment. Resident #37's Care Plan Report included a focus area initiated 12/13/2024, that indicated the resident had a heightened safety risk related to confusion and a personal desire to smoke. Interventions directed staff to apply protective non-flammable apron or cover/barrier during smoking activity (initiated 12/13/2024), keep the resident's cigarettes (initiated 12/13/2024), and keep the resident's lighter(s) (initiated 12/13/2024). Further review of the Care Plan Report included a focus area initiated 01/31/2025, that indicated the resident was noted to smoke used cigarettes found on the ground. Interventions directed staff to post cigarette times in the resident's room (initiated 01/31/2025); explain the risks and benefits to the resident, including the risk of infection (initiated 01/31/2025); and indicated that the resident refused to give staff their lighter (initiated 02/10/2025). Resident #37's Medical Professional Note, dated 12/13/2024, indicated for the resident's diagnosis of tobacco abuse, the resident was counseled and advised to quit and the impact of smoking cessation was discussed in detail. Per the Medical Professional Note, several options, to include patches and gums, medication management, relaxation techniques, and to avoid the company of other smokers were discussed with resident. Resident #37's Smoking - Initial Assessment, dated 01/31/2025, indicated the resident was a smoker with cognitive loss, who smoked two to five times per day. Per the Smoking - Initial Assessment, the resident required a smoking apron and supervision. The Smoking - Initial Assessment indicated the facility stored the resident's smoking materials and a plan of care was used to ensure the resident was safe while smoking. During an interview on 03/14/2025 at 1:09 PM, the MDS Coordinator stated she completed the initial smoking assessment for Resident #37 on 01/31/2025 and verbally communicated with the staff about the care plan interventions on that day, but the communication was not documented anywhere. During an interview on 03/11/2025 at 8:52 AM, the DON stated residents had an initial assessment completed, a smoking safety assessment, an evaluation of whether the resident smoked or not, and a care plan would be completed if the resident smoked. She stated the assessments were completed by the charge nurse The DON stated from what she remembered, Resident #37 was not a smoker initially. She stated that around January 2025, staff observed the resident gathering cigarette butts and trying to smoke them and that was when staff realized the resident smoked, so staff assessed the resident as a smoker at that time. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Riverbank Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2649 Topeka Street Riverbank, CA 95367	

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #37's Activities-Progress Notes, dated 03/03/2025 at 10:30 AM, revealed activities staff witnessed Resident #37 smoking on the back patio during a non-smoking time. The note indicated the resident had a lighter, and the activities staff member notified the resident of the designated smoking times and asked the resident to turn in their lighter. The note indicated the resident refused to turn their lighter in to the activities staff member. Resident #37's Activities-Progress Notes, dated 03/04/2025 at 11:30 AM, revealed an activities staff member spoke with Resident #37 and notified them of the facility's smoking policy. According to the note, the resident refused to sign a copy of the smoking policy that was discussed with them. Resident #37's Administrator Notes, dated 03/04/2025 at 4:11 PM, revealed the Administrator contacted the Ombudsman regarding Resident #37's noncompliance with care and smoking. The note indicated the facility received verbal consent to the facility's admission agreement, which included the smoking policy, from Resident #37's family. According to the note, the Administrator informed the resident if they wanted to smoke, they must follow the facility's smoking policy. The note indicated the Administrator informed the resident that if they desired unlimited smoking freedom, then a discharge to another location may be best for the resident. According to the note, the Administrator informed the Ombudsman that Resident #37 was a potential risk to themself or other residents if their noncompliance continued. Per the note, at the recommendation of the Ombudsman, the Administrator agreed to seek discharge for the resident. Resident #37's Activities-Progress Notes, dated 03/05/2025 at 10:36 AM, revealed an activities staff member witnessed Resident #37 smoking outside of the door which led to the back patio. The note indicated the staff member advised the resident they could not smoke outside of the designated times and asked the resident to extinguish their cigarette, but the resident refused and continued smoking until the resident was finished. Resident #37's Activities Progress Note, dated 03/10/2025 at 6:33 PM, indicated the Activity Supervisor was outside sweeping the designated smoking area when Resident #37 came outside looking for cigarette butts. According to the note, the Activity Supervisor explained the facility's smoking policy to the resident and informed the resident they could not pick up cigarette butts from the ground. The note indicated Resident #37 became agitated and attempted to swing at the staff member, then cursed and walked back into the building. Per the note, the Administrator and DON were notified. During a concurrent observation and interview on 03/10/2025 at 3:27 PM, Resident #37 removed a butane cigarette lighter out of their jacket. Resident #37 stated they went outside to smoke by their self whenever they wanted to. During a concurrent observation and interview on 03/10/2025 at 3:43 PM, the surveyor noted Resident #37 wore a gray hospital gown that had multiple brown holes visible through the fabric. There were two small holes near the mid chest area on the left side, one small hole on the left upper chest area, and one dime size hole near the resident's right leg. Resident #37 stated the holes in their gown was from cigarette ashes but was unable to remember when the holes occurred. The resident stated they did not use a smoking apron. (continued on next page)

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Riverbank Post-Acute	2649 Topeka Street Riverbank, CA 95367

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

During an interview on 03/10/2025 at 3:53 PM, Certified Nursing Assistant (CNA) #5 stated Resident #37 was independent and refused care. CNA #5 stated the resident went outside with activities staff when they wanted to smoke. She stated that she believed staff knew that the resident smoked, but the resident wandered around and went by their self.

During an interview on 03/10/2025 at 4:17 PM, Licensed Vocational Nurse (LVN) #6 stated she had no idea how the resident got the burn holes on their gown. LVN #6 stated she was unsure if the resident smoked.

During an interview on 03/11/2025 at 2:24 PM, Activity Staff (AS) #1 stated she witnessed Resident #37 go smoke a couple of times and she tried to get them to sign a smoking policy, but the resident refused. She stated she told the resident that smoking could not be done outside of designated smoking times. AS #1 stated the resident had their own lighter, and the cigarettes were obtained from the ash tray or off the ground on the back patio, where everyone smoked. She stated the resident refused to give her their lighter and then she reported it to the Administrator. She stated that the incident occurred at the end of February 2025 or the beginning of March 2025 and that she had not seen the resident smoke prior to that incident.

During an interview on 03/11/2025 at 8:52 AM, the DON stated that once a resident was identified as a smoker, the resident was not to have their cigarettes or lighter because it was a safety issue. She stated if they were found with a cigarette or a lighter, then it would be removed, and education provided. The DON stated if a resident refused to follow the policy, then a discharge notice would be provided to the resident.

During an interview on 03/15/2025 at 1:36 PM, the DON stated there should have been additional interventions implemented at the time Resident #6 had a lighter on 02/10/2025, to include removal of the lighter, education to the resident, and supervision of the resident.

During an interview on 03/11/2025 at 9:13 AM, the Administrator stated residents were assessed by nursing staff at admission to determine their desire to smoke. He stated there was a smoking area with designated times, and the activities staff took the residents who smoked to the designated area. The Administrator stated he was not aware that Resident #37 had burn areas on their gown. The Administrator stated the Ombudsman was contacted regarding the resident's smoking.

During an interview on 03/13/2025 at 4:06 PM, the Administrator stated a discharge notice had not been issued to Resident #37 yet, as a safe placement had to be identified before the resident could be discharged .

During an interview on 03/14/2025 at 8:58 AM, the Administrator stated that prior to Monday, 03/10/2025, the interventions staff implemented was that a smoking assessment was completed for Resident #6, monitoring was completed by nursing staff each shift, the facility attempted to get the resident to sign the smoking agreement a few times, and discharge had been discussed with the Ombudsman in February 2025 and on 03/04/2025.

On 03/14/2025 at 10:08 AM, a Removal Plan was submitted by the facility and accepted by the State Agency. It read as follows:

1. Immediate Smoking Assessments:

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. As of 03/12/2025, all five identified residents who smoke were immediately assessed for safety risks, including cognitive impairment and ability to handle smoking materials safely. Residents were identified based on their current desire to smoke. The resident smoking assessment titled, Resident Smoking Initial Assessment, was completed by the Director of Nursing on 03/12/2025 for the five residents identified. The assessments were completed, and the residents' care plans were updated accordingly on 03/12/2025 by the Director of Nursing. b. The active smoker list was updated on 03/12/2025 to included Resident #37. c. All residents were previously assessed on admission for a desire to smoke. All new residents will be assessed on admission if they have a desire to smoke. This will be completed by admitting nurse. d. All five identified residents were re-educated by the Director of Nursing on the risk vs benefit of following the smoking policy on 3/12/25. e. All other necessary interventions including supervised smoking, appropriate storage of smoking materials, smoking in designated areas, and offering of aprons were implemented immediately on 3/12/25. 2. Immediate Supervision Implementation: a. The smoking program was reviewed on 03/12/2025 for resident safety by the interdisciplinary team including the Administrator, Activities Director, Director of Nursing, Medical Records Director, Director of Staff Development, Social Services, and the Medical Director. b. Staff were educated on 03/12/2025 by the Director of Staff Development. Staff education included nurses, nurse assistants, activity assistants, department heads, dietary, administration, and housekeeping. Education included how to ensure smoking activities occur in designated, supervised areas to prevent unsupervised smoking and reduce fire hazards. Additionally, staff were trained on the importance of supervision and monitoring of smoking residents, including the prevention of unsafe practices. Education will be ongoing with an expected completion of all staff by 03/14/2025. Education will be conducted by the Director of Staff Development or designee. Any additional staff or new staff will be given a one on one education prior to start of shift. c. Training on the importance of supervision and monitoring of smoking residents, including the prevention of unsafe practices will be provided for all new hires by Director of Staff Development as part of the orientation process. 3. Restriction of Smoking Materials: a. Any potentially dangerous items, including lighters or cigarettes, have been removed from (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	residents' rooms. This was completed on 03/12/25 by Activity Director b. A lighter was removed from Resident #37's room on 03/10/2025 at 5 :00 PM by CNA. c. On 03/12/2025, all rooms were visually inspected, and residents were asked for any smoking paraphernalia. There was no additional smoking paraphernalia. This was completed on 3/12/25 by Activity Director d. The Activities Director will conduct a monthly sweep visually inspecting all resident rooms and asking for smoking paraphernalia. The Activity Director was educated to this responsibility on 03/13/2025 by the Administrator and Director of Nursing e. All Staff including nurses, nurse assistants, activity assistants, department heads, dietary, administration, and housekeeping educated by the Director of Staff Development on 03/13/2025 that staff who identify smoking paraphernalia should report it to Administrator or designee. All staff off site were educated via phone by department heads, administrator or designee on 3/13/25 and 3/14/25. 4. Revised Smoking Policy and Agreement Enforcement: a. A smoking agreement has been reintroduced and enforced for all residents who smoke, with clear guidelines about safe smoking practices, supervision, and the need to follow all facility policies. The smoking agreement was revised to better match the facility's smoking policy and procedure. A revision was made indicating that aprons are offered and strongly encouraged based on assessment, instead of requiring an apron to be eligible for the smoking program. b. Residents have the right to refuse smoking apron. Staff will continue to offer and encourage the apron. In the event of a refusal, the resident will be educated on the risk vs. benefit of the apron use. The resident will be provided supervision during smoking by Activity aide or designee during smoke break. Fire blanket and fire extinguisher are available in smoking area. c. Staff assisting residents who refuse to wear apron will notify the Activity Director or designee. Activity aides were trained on 3/13/25 by Activity Director. The Activity Director or designee will bring this to the attention to the interdisciplinary team during the interdisciplinary team meeting. This will then be care planned by nursing during the interdisciplinary team meeting. d. Residents who refuse to sign the agreement will have their smoking materials stored securely and will only be allowed to smoke under direct supervision. Residents who refuse to sign will be asked to turn in any smoking paraphernalia. If resident refuses to voluntarily give up paraphernalia the interdisciplinary team including the administrator, director of nursing, activity director, medical record director, director of staff development, infection preventionist, social services or other designee, will confiscate smoking materials as per our policy or discharge the resident. e. Residents who refuse to sign will be placed on every shift visual monitoring for smoking paraphernalia. Monitoring will be done by licensed nurses. Licensed nurses were trained by Director of Staff Development and Director of Nursing on 3/13/25. 5. Staff Education and Training: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. On 03/12/2025, facility staff, including nurses, nurse assistants, activity assistants, department heads, dietary, administration and housekeeping, have been immediately educated on the updated smoking policy, the importance of smoking assessments, and how to ensure that all smoking activities are managed safely. The education was conducted by the Director of Staff Development. 6. Environmental Safety Measures: a. Fire safety training was given on 12/11/2024 and 02/20/2025 by fire training vendor. b. Additionally, fire safety training was done by the Director of Staff Development on 03/14/2025. Staff educated included nurses, nurse assistants, activity assistants, department heads, dietary, administration and housekeeping. Training was completed, and additional fire safety measures, such as fire extinguishers and fire blankets near designated smoking areas, have been implemented. Staff not currently in facility were called and educated by the Director of Staff Development via phone on 3/13/25 and 3/14/25. c. Safe smoking area training was done for the Activities Director and activity assistants on 03/11/2025. Training was done by the Director of Staff Development and Administrator. d. Activities and or designee will do a check after each smoke break to ensure that smoking areas are safe and free from hazards such as loose smoke buds. Aides will verify receptacle is in working order, fire extinguisher is in place and fire blanket is in present. Activity aides were trained on 3/11/25 by activity director and administrator on 3/11/25. e. Activity aides will supervise that all cigarettes will be extinguished and disposed in proper receptacle of after each smoking break. Activity aides were trained by activity director and administrator on 3/11/25. f. A weekly scheduled audit conducted by the Medical Records Director or designee to review and monitor compliance with safety procedures. g. Compliance of audits conducted by the Medical Records Director will be monitored for three months and will be added to the Medical Record Director's portion (or designee) for our [quality assurance performance improvement] QAPI meeting, quarterly thereafter. Corrective Action Completion Date: The Immediate Jeopardy removal actions have been completed as of 03/14/2025, and the facility will continue to monitor compliance on an ongoing basis. X. All corrections were completed on 3/14/25. X. The immediacy of the IJ was removed on 3/14/25. Onsite Verification: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was removed on 03/14/2025 at 3:40 PM after the survey team verified the implementation of the facility's Removal Plan as follows: 1. The survey team reviewed and verified the facility completed smoking assessments for the five residents who smoked in the facility, their care plans were updated, and verified the Active Smokers list had been updated to include Resident #37. The survey team also reviewed and verified the facility reviewed the smoking policy with the five residents. Interviews on 03/14/2025 with the five residents verified facility staff discussed the smoking policy and procedures with the residents. 2. The survey team conducted interviews with the Administrator, the Activity Supervisor, the DON, the Medical Records Staff, the Director of Staff Development, Social Services Supervisor, and the Medical Director to discuss their understanding of the facility's smoking program. The survey team reviewed and verified the facility provided staff training on 03/13/2025 at 4:00 PM through a review of a facility document titled, [the facility's name] Lesson Plan. Per the document, the training was related to smoke breaks, observing smoke breaks, ensuring smoking occurred in designated areas, smoking assessments, fire safety, providing a smoking apron, reporting finding smoking paraphernalia to the Administrator or designated supervisor, and understanding how to extinguish residents in case of an emergency. The team conducted interviews with staff, including CNAs, LVNs, registered nurses (RNs), housekeeping staff, and activities staff to verify training was provided. 3. The survey team reviewed a facility document titled, Secure Smoking Paraphernalia, that indicated that each of the five smoker's rooms were inspected on 03/10/2025. The document indicated that a lighter was confiscated from Resident #37's room on 03/10/2025. The documented indicated that the remainder of the rooms were inspected on 03/12/2025. The survey team confirmed with the Activity Supervisor that room inspections would be continued on a monthly basis and confirmed that a lighter was removed from Resident #37's room. During an interview on 03/11/2025 at 1:34 PM, Resident #37 stated that someone took their lighter on 03/10/2025. 4. The survey team reviewed an undated facility policy titled, Smoking Policy that indicated that the smoking policy would be reviewed with the residents or their legal representative and a signed copy of acknowledgement would be maintained in the resident's health record. The policy indicated that residents would not be able to keep smoking items in their possession, and indicated the smoking aprons would be offered and encouraged to all residents based on assessment. The policy included lines where the resident or their representative as well as a witness could sign. The survey team confirmed through interviews with staff what to do if residents refused to sign the smoking agreement, if they refused to wear a smoking apron, or if they refused to turn in their smoking paraphernalia. An observation of a smoke break on 03/14/2025 at 1:56 PM revealed multiple smoking aprons hung in the area. Two residents were offered a smoking apron and both residents refused. The Activity Supervisor witnessed the refusals. 5. The survey team reviewed and verified the facility provided staff training on 03/13/2025 at 4:00 PM through a review of a facility document titled, [the facility's name] Lesson Plan. Per the document, the training was related to smoke breaks, observing smoke breaks, ensuring smoking occurred in designated areas, smoking assessments, fire safety, providing a smoking apron, reporting finding smoking paraphernalia to the Administrator or designated supervisor, and understanding how to extinguish residents in case of an emergency. The team conducted interviews with staff, including CNAs, LVNs, RNs, housekeeping staff, and activities staff to verify training was provided. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The survey team reviewed facility documents titled, Fire Drill Report dated 12/11/2024 and 02/20/2025 that indicated fire drills were conducted on those days. An observation of a smoke break on 03/14/2025 at 1:56 PM revealed a fire blanket and fire extinguisher on the exterior wall of the facility in the area. A facility document titled, Safe smoking Activity Assistant Training log indicated that AS #1, AS #9, and AS #10 were trained related to a safe smoking area. The survey team reviewed a facility document titled, Smoking Area Safety Check, that indicated staff checked the smoke areas five times per day. The survey team reviewed a facility document titled, Performance Improvement Project (PIP) Guide, dated 03/12/2025, that indicated the facility initiated a PIP related to smoking practices at the facility. The survey team conducted interviews with activities staff, the Medical Records Staff, and the Administrator to confirm training was provided and a system to monitor for compliance was established.

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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. 52066 Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of 5 percent (%) or less. There were 2 errors out of 26 opportunities, which resulted in a medication error rate of 7.69% for 1 (Resident #12) of 8 residents observed for medication administration. Findings included: A facility policy, titled, Administering Medications, revised 04/2019, indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. An Admission Record indicated the facility admitted Resident #12 on 11/19/2024. According to the Admission Record, the resident had a medical history that included diagnoses of muscle weakness and age-related osteoporosis. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/05/2025, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) of 9, which indicated the resident had moderate cognitive impairment. Resident #12's Order Summary Report for active orders as of 03/13/2025, revealed an order dated 11/19/2024, for calcium 600 +D plus minerals oral tablet 600-400 milligrams (mg), give one tablet by mouth two times a day for supplement and an order dated 11/19/2024, for cranberry oral capsule, give 425 mg by mouth one time a day for preventive for urinary tract infection. During medication administration observation on 03/12/2025 at 7:17 AM, Licensed Vocational (LVN) #2 administered medications to Resident #12 to include one cranberry 450 mg tablet and one Oyster Shell Calcium 500 mg tablet. During an interview on 03/13/2025 at 10:05 AM, LVN #2 stated she been trained and was expected to administer the right medication to the residents. According to LVN #2, if the facility did not have the correct medication, she would notify the physician to see if they wanted to change, hold, or provide an alternative medication. LVN #2 stated the Oyster Shell Calcium 500 mg tablet and the cranberry 450 mg tablets were the only ones the facility had in-house as stock medications. During an interview on 03/13/2025 at 10:18 AM, the Director of Nursing (DON) stated staff were trained and expected to administer medications based upon the resident medication rights. The DON stated if a medication was not available, then the physician would be notified, and a follow-up with pharmacy would occur. During an interview on 03/13/2025 at 10:27 AM, the Administrator stated he expected staff to administer medications correctly.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 51749 Based on interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #6) of 19 sampled residents did not experience significant medication errors. Specifically, Resident #6 did not receive their antidepressant, diuretic, anticoagulant, and blood pressure medications as ordered by the physician three days each week when the resident was out of the facility at dialysis. Findings included: A facility policy, titled, Administering Medications, revised 04/2019, indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. An Admission Record revealed the facility admitted Resident #6 on 04/06/2024. According to the Admission Record, the resident had a medical history to include diagnoses of acute pulmonary embolism, dependence of renal dialysis, major depressive disorder, hypotension, chronic embolism and thrombosis of left lower extremity, and chronic kidney disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/30/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #6's Care Plan Report included a focus area initiated 12/29/2023, that indicated the resident needed dialysis related to a diagnosis of end stage renal disease. Interventions indicated the resident's dialysis days were Mondays, Wednesdays, and Fridays, with a chair time of 6:30 AM on each day. Resident #6's Medication Administration Record [MAR] for the timeframe 03/01/2025 - 03/31/2025, revealed the transcription of the following orders: - an order with a start date of 06/30/2024 and a discontinue date of 03/13/2025, for fluoxetine hydrochloride (HCL) (an antidepressant medication) oral capsule 10 milligram (mg), give one capsule by mouth one time a day for crying spells and irritability. - an order with a start date of 04/07/2024 and a discontinue date of 03/13/2025, for Lasix (a diuretic medication) oral tablet 20 mg, give one tablet by mouth one time a day for pulmonary edema. - an order with a start date of 04/06/2024, for Eliquis (an anticoagulant medication) oral tablet 5 mg, give 5 mg by mouth two times a day for chronic embolism. - an order with a start date of 06/20/2024 and a discontinue date of 03/13/2025, for metoprolol tartrate (a blood pressure medication) oral tablet 25 mg, give one tablet by mouth every 12 hours and hold for a systolic blood pressure of less than 100 millimeters of mercury a heart rate less than 60 beats per minute. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Riverbank Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2649 Topeka Street Riverbank, CA 95367	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the MAR, there was no evidence to indicate fluoxetine HCL, Lasix, Eliquis, or metoprolol tartrate were administered to the resident on 03/03/2025 (Monday), 03/05/2025 (Wednesday), 03/07/2025 (Friday), 03/10/2025 (Monday), and 03/12/2025 (Wednesday). During an interview on 03/13/2025 at 2:15 PM, Licensed Vocational Nurse (LVN) #7 reviewed Resident #6's MAR for the timeframe 03/01/2025 - 03/31/2025 and stated the resident did not receive those medications (fluoxetine, Lasix, Eliquis, and metoprolol) because the resident was at dialysis. LVN #7 stated she did not think about the resident missing those medications three times each week because they were at dialysis. According to LVN #7, this was something the physician should have been notified of. During an interview on 03/13/2025 at 3:52 PM, LVN #2 reviewed Resident #6's MAR for the timeframe 03/01/2025 - 03/31/2025 and stated she notified the physician of the resident missing those medications ((fluoxetine, Lasix, Eliquis, and metoprolol) three times each week, but could not find any documentation to show evidence the physician had been notified. During an interview on 03/14/2025 at 4:00 PM, Medical Doctor (MD) #3 stated he would like to be notified when the resident missed medications three times each week. MD #3 stated the resident's medications could be adjusted so that they would receive their medications as ordered. According to MD #3, he had not heard of any changes in the resident's mood as the result of the fluoxetine not being administered; the Eliquis was ordered twice a day and it was better to give the medication as ordered; and since the resident was compliant with their dialysis treatment, there was no negative effect of the resident not receiving Lasix as ordered. During an interview on 03/15/2025 at 9:45 AM, the Director of Nursing (DON) stated residents who went out to dialysis should receive their medications before they leave the facility, if there were no contraindications. The DON stated staff were expected to administer medications as ordered by the physician. During an interview on 03/15/2025 at 9:56 AM, the Administrator stated he deferred all questions related to medications being administered prior to dialysis to nursing; however, staff were expected to follow the physician's order. During an interview on 03/15/2025 at 1:28 PM, the Pharmacist stated he thought it would significantly impact the health of Resident #6 to miss medications three times each week. According to the Pharmacist, if the resident did not receive fluoxetine as ordered, the resident could experience depressive symptoms; not being administered Eliquis, could cause a blood clot to form and place the resident at risk for a stroke; and if Lasix was not taken, the resident's lungs could fill with fluid, which could cause shortness of breath and/or fluid overload, which could place the resident at risk for bacterial pneumonia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbank Post-Acute	2649 Topeka Street Riverbank, CA 95367

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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. 44899 Based on observation, interview, and record review, the facility failed to maintain an effective infection control program when one of nine sampled residents' (Resident 9) oxygen concentrator (a device that concentrates the oxygen from the ambient air) filter was found covered with dust and lint. This failure placed Resident 9 at an increased risk to develop respiratory and healthcare-associated infections. Findings: During a review of Resident 9's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 4/10/25, the AR indicated, Resident 9 was admitted from an acute care hospital on 2/22/24 to the facility, with diagnoses that included End Stage Renal Disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), Congestive Heart Failure (CHF- weakness in the heart where fluid accumulates in the lungs), Type 2 Diabetes Mellitus (DM2- abnormal levels of blood sugar), and Chronic Obstructive Pulmonary Disease (COPD- is a chronic inflammatory lung disease that causes obstructed airflow of the lungs). During a review of Resident 9's Order Summary Report (OSR), dated 4/10/25, the OSR indicated, . Order Summary . Oxygen at 2L/MIN [liter/minute, unit of measurement) via Nasal Cannula (a device used to deliver supplemental oxygen) for WHEEZING/SOB [shortness of breath]. During a concurrent observation and interview, on 4/10/25, at 1:45 p.m., in Resident 9's room, with the Registered Nurse Supervisor (RNS), the RNS looked at Resident 9's oxygen concentrator and stated the oxygen concentrator filter was covered with dust and lint. The RNS stated using a dirty oxygen concentrator was not acceptable. RNS stated Resident 9's was not getting the full benefit of supplemental oxygen and his shortness of breath could worsen. The RNS stated maintaining the cleanliness of an oxygen concentrator was the responsibility of the licensed nurses. During an interview on 4/10/25, at 4:58 p.m., with the Director of Nursing (DON) and the Director of Staff Development (DSD), the DON stated the purpose of the oxygen concentrator was to improve resident's oxygen level. The DON stated using a dirty oxygen concentrator was not acceptable and could potentially cause residents to become ill. The DON stated residents using a dirty oxygen concentrator could have respiratory infection. The DON stated she expects the oxygen concentrator to be cleaned weekly and as needed by the licensed nurses for the safety and well-being of all residents receiving oxygen. During a review of the facility ' s document titled, Job Description: Licensed Vocational Nurse, undated, the document indicated, . Safety and Sanitation . Adheres to all relevant healthcare regulations and facility policies . Ensures a safe and clean environment for residents and staff . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s document titled, Job Description: Registered Nurse, undated, the document indicated, . the incumbent shall meet and fulfill all applicable requirements as outline in California Code of Regulations Title 22 . as well as the Health and Safety Code for the State of California . During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control, dated 10/18, the P&P indicated, . An infection prevention control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections . During a review of the facility's P&P titled, Departmental (Respiratory Therapy) - Prevention of Infection, dated 11/11, the P&P stated, . The purpose of this procedure is to guide prevention of infection . Steps in the Procedure . Related to Oxygen Administration . 9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry . During a review of the oxygen concentrator manual titled, [Brand X] Oxygen Concentrator User Manual, dated 11/09, the manual indicated, . Cleaning the Cabinet Filter . 1. Remove the filter and clean at least once a week depending on environmental conditions. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. 3. Dry the filter thoroughly before reinstallation .