

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055887	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/04/2024
NAME OF PROVIDER OR SUPPLIER River Bend Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2215 Oakmont Way West Sacramento, CA 95691	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>43247</p> <p>Based on observation, interview, and record review, the facility failed to provide care according to professional standards of practice for one of three sampled residents (Resident 1), when the facility did not obtain instructions for follow up care for Resident 1 who had electrodes placed for an EEG (electroencephalogram- measures electrical activity in the brain) machine and appointment for removal of electrodes was missed.</p> <p>This failure had the potential to have caused the scalp skin injuries after the electrodes were removed at the facility.</p> <p>Findings:</p> <p>A review of Resident 1's Admission Record indicated Resident 1 was admitted to the facility initially in June 2013 with multiple diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke-lack of blood flow to the brain), quadriplegia (paralysis of all four limbs), and epilepsy (a seizure disorder).</p> <p>A review of Resident 1's Order Summary Report, active orders as of 10/4/24, indicated order 9/23/24, . medical device (EEG) Pressure injury (on scalp to forehead): - Cleanse with wound cleanser or normal saline and pat dry. Apply zinc oxide paste [medicated cream], and leave open to air, every shift for medical device injury apply calcium alginate [wound treatment] over Zinc paste if drainage noted from areas .</p> <p>A review of Resident 1's Progress Notes, dated 9/16/24, indicated .Resident was sent out for an Appointment: Neurology .son .will attend .Resident left facility at 6:30 am. Resident returned to facility at 9:10 am. Resident recieved [sic] an ambulatory EEG. Resident is required to wear the electrodes continuously for the duration of the testing either a 24hr [hour] or 48hr recording. The natus [sic] EEG box contains a microcomputer which will be recording brain activity .</p> <p>A review of Resident 1's Progress Note, dated 9/18/24 at 10:45 a.m., indicated .residents son/RP [Responsible Party] in facility in resident's room .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Change in Condition Evaluation, dated 9/19/24, indicated .seen skin damage when medical device electrodes patches (EEG) were removed from scalp as per hospital recommendation . multiple upper to front scalp and forehead open areas medical device (EEG) related PI [Pressure Injury-injury to skin and underlying tissue caused by prolonged pressure to area], medical device was applied by hospital a few days ago, seen skin damage when medical device electrodes patches (EEG) removed from scalp .Tissue quality appears to be 100% epithelial [superficial cells covering skin] with mild purulent [milky discharge from wound] drainage .Pt [patient] non verbal unable to communicate pain, facial grimacing noted during removal of electrode patches .</p> <p>A review of Resident 1's Progress Note, dated 9/20/24 at 1:47 a.m., indicated .Resident Son/RP/POA [Power of Attorney] called at 2338 [11:38 p.m.] rt [related to] the wounds present on scalp and forehead after EEG electrode removal on 09/19 PM [evening] shift. RP expressed he was not comfortable with his mother remaining in facility the duration of the night and requested a transfer to ED [Emergency Department]. RP was reassured by writer and RN on shift that resident's condition was stable, she is displaying her baseline indications of pain and that her wounds are being monitored closely and managed by treatments. RP maintained request. Request honored .resident sent out to [acute care hospital] . at 01:47 am .</p> <p>A review of Resident 1's After Visit Summary, dated 9/20/24, indicated .You were seen for healing scalp wounds secondary to EEG electrode removal. These wounds appear to be healing well and do not show any signs of infection .</p> <p>A review of Resident 1's Surgical Consult, dated 9/24/24, indicated .WOUND .Right Medial [toward the center] Scalp .Etiology: Iatrogenic Injury [injury caused by medical treatment] .Wound SIGNS OF INFECTION: None .The patient has a wound located at the right medial scalp .Length (cm-centimeter) 1.0 Width (cm) 1.0 Depth (cm) 0.1 .The wound is stable and requires continued topical wound dressing therapy .</p> <p>During a concurrent observation and interview on 10/4/24 at 2:07 p.m. with Certified Nursing Assistant (CNA) 1 of Resident 1, observed forehead and lower scalp with multiple areas with slight discoloration and white bandage with small amount of blood stain on top of head. CNA 1 confirmed multiple areas of discoloration on Resident 1's forehead and bandage on top of head. CNA 1 stated she had noticed the patches on Resident 1 and that she has cream applied to the patches.</p> <p>During an interview on 10/4/24 at 2:12 p.m. with Licensed Nurse (LN) 1, LN 1 stated Resident had an EEG machine placed about two weeks ago and was supposed to return for follow up appointment. LN 1 stated EEG department did not send paperwork for follow up. If had returned with paperwork she would have notified Social Services to arrange follow up appointment. Resident 1's Family Member (FM) reported that Resident 1 was to return for follow up appointment on 9/19/24. Reviewed with LN 1, Resident 1's hard copy chart at nursing station. LN 1 acknowledged there was no documentation in chart from appointment on 9/16/24. LN 1 stated Resident 1's EEG electrodes were removed by the Director of Nursing (DON).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/4/24 at 2:23 p.m. with the DON, the DON stated Resident 1 had a follow up appointment on 9/19/24 to remove the EEG electrodes but Resident 1's FM did not notify the facility of the appointment. On 9/19/24, the EEG department contacted facility and requested the EEG machine be returned that day. The DON stated she asked the EEG department if they could remove the electrodes at the facility. The DON stated she was instructed on how to remove the electrodes by the EEG department.</p> <p>The DON stated the electrodes were on multiple sites and were red. The DON stated if the electrodes had stayed on longer could have created pressure ulcers. The DON stated that paperwork did not come back with Resident 1 on 9/16/24 after appointment to have EEG machine placed and that the FM likely had the paperwork from the appointment. The DON, when asked what would have happened if the EEG department had not contacted the facility on 9/19/24, stated, Going to figure it out after three days. Would have been more involved if in charge of appointment, not [FM].</p> <p>During an interview on 10/4/24 at 2:47 p.m. with the Social Services Director (SSD), the SSD stated Social Services arranged transportation for Resident 1 to EEG department appointment on 9/16/24 and FM went with her. The SSD stated usually comes back with paperwork or paperwork is faxed. If not received would follow up and request documentation. SSD stated on 9/19/24, Resident 1's family texted staff member and notified her of follow up appointment but it was not conveyed to social services to set up transportation to appointment.</p> <p>During a telephone interview on 10/4/24 at 3:03 p.m. with LN 3, LN 3 stated Resident 1's EEG machine was placed on 9/16/24. LN 3 stated after three or four days she observed a little drainage from electrode sites. The EEG department contacted facility on 9/19/24 to have EEG machine returned. The DON removed the electrodes on 9/19/24 and some of the skin had been peeled off. LN 3 stated Resident 1's FM was in the facility on 9/18/24 at 6:00 a.m. and reported to her that Resident 1 had an appointment on 9/18/24. The FM reported to her that he had handed paperwork to nurse on 9/16/24 but did not know the name of the nurse. LN 3 stated Resident 1's FM reported he had texted LN 5 about follow up appointment. LN 3 stated Resident 1's FM had not provided any paperwork to facility.</p> <p>During a telephone interview on 10/4/24 at 4:14 p.m. with LN 4, LN 4 stated Resident 1 went to appointment on 9/16/24 with FM to have EEG machine placed. LN 4 stated when Resident 1 returned, she asked FM if there was any paperwork. LN 4 stated Resident 1's FM showed her paper with instructions that said to remove in 24 to 48 hours. LN 4 stated she transcribed the information into a progress note and paperwork was returned to the FM. LN 4 stated she did not make a copy of the provided paperwork. LN 4 stated Resident 1's FM reported to her he had notified social services of follow up appointment. LN 4 stated she assumed that social services knew because FM stated he had spoken with social services. LN 4 also stated Resident 1's FM told her he had notified a nurse about the follow up as well.</p> <p>During an interview on 10/4/24 at 4:35 p.m. with the Administrator (ADM), the ADM stated Resident 1 had redness on the scalp and when electrodes were removed had an open area on the scalp.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 10/4/24 at 4:53 p.m. with Patient Care Services (PCS) for EEG department, the PCS stated Resident 1 had appointment for EEG machine electrodes to be placed on 9/16/24. The PCS stated Resident 1 had a follow up appointment scheduled on 9/18/24 at 7:00 a.m. to remove the device. The PCS stated she spoke with Resident 1's FM on 9/18/24 who said he was still waiting for a ride at the facility and then placed multiple calls to him that day that he did not answer. The PCS stated Resident 1 did not show up for appointment on 9/18/24. The PCS stated she spoke with facility staff on 9/18/24 to reschedule but did not hear back that day. The PCS stated she called facility on 9/19/24 and spoke with staff who said they would notify the DON. The PCS stated the facility removed the electrodes on 9/19/24 on their own. The PCS stated she did not know who may have instructed the facility on how to remove the electrodes. The PCS stated on 9/16/24, paperwork with instructions on how to care for the EEG machine and follow up appointment was scheduled on 9/18/24, was sent with Resident 1.</p> <p>During an interview on 10/4/24 at 5:00 p.m. with the DON, the DON stated she was not aware that Resident 1's follow up was scheduled for 9/18/24 and not 9/19/24. When asked what the expectation of staff if resident does not return from appointment with instructions or any paperwork, the DON stated, [Resident 1's FM] wanted to manage the care and did not provide the information to the facility.</p> <p>During a telephone interview on 10/8/24 at 4:11 p.m. with LN 5, LN 5 stated Resident 1 had EEG machine placed on 9/16/24. LN 5 stated usually residents come back from appointments with paperwork. Resident 1's FM mentioned to LN 5 that the electrodes were supposed to be removed at the EEG department where they were placed. LN 5 stated Resident 1's FM had texted her about the initial appointment on 9/16/24 but no other texts and was not aware of any scheduled appointment on 9/18/24. When asked what should have happened if Resident 1 returned from appointment on 9/16/24 without any follow up information, LN 5 stated, Should have called the EEG department to get information about when to return. It is the SSD's job to set up transportation and arrange appointments. Should have gone through any paperwork upon return and see what the follow up is.</p> <p>Requested facility policy and procedures for Nursing Responsibilities, Nursing Communication, and Appointments. Policies were not provided.</p>		