

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  08/21/2025
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)
F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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
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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>Based on interview and record review, the facility failed to ensure physician orders and consistent monitoring were followed in accordance with professional standards for Resident 1, when Resident 1's side effects were not consistently monitored and treatments not done as ordered by the physician. This failure had the potential to negatively affect Resident 1's health and their ability to achieve their highest practical well-being. Resident 1 was originally admitted to the facility in May 2024 with multiple diagnoses which included sepsis (extreme response to infection) due to methicillin resistant staphylococcus aureus (type of bacteria), urinary tract infection (infection in the urinary system), type 2 diabetes mellitus (condition where the body either doesn't produce enough insulin or doesn't respond properly to the insulin), cellulitis (skin infection) of left lower limb, pain in right hip, and dysphagia (difficulty swallowing foods or liquids). A review of Minimum Data Set (MDS, an assessment tool), dated 2/5/25, indicated Resident 1 had impaired cognition. A review of Resident 1's Order Summary Report, with start date 2/3/25, indicated, Preparation H [medication used to relieve the symptoms of hemorrhoids, such as itching, swelling, and discomfort] Rectal Ointment 0.25-14-74.9 % (Phenylephrine-Mineral Oil-Petrolatum) Insert 1 application rectally every day and night shift for skin maintenance. A review of Resident 1's Medication Administration Record (MAR-a legal document used to record medications given to the residents), for the month of February 2025, indicated ointment for skin maintenance was not applied on 2/4/25, 2/5/25, 2/6/25, 2/7/25, 2/8/25 and 2/9/25 as physician ordered. A review of Resident 1's Order Summary Report, with start date 2/5/25, indicated, MIDLINE [midline catheter is a thin, soft tube that is placed into a vein, usually in the arm]: Flush before and after administration of medications with 10ml [milliliters-unit of measurement] NS [normal saline] every shift. A review of Resident 1's MAR for the month of February 2025, indicated midline flushing was not done on 2/7/25, 2/8/25, 2/9/25, 2/12/25, and 2/15/25 as physician ordered. A review of Resident 1's Order Summary Report, with start date 2/5/25, indicated, MIDLINE: Monitor every shift for s/s [signs and symptoms] of infection every shift. A review of Resident 1's MAR for the month of February 2025, indicated monitoring for midline infection was not done on 2/7/25, 2/8/25, 2/9/25, and 2/15/25 as physician ordered. A review of Resident 1's Order Summary Report, with start date 1/31/25, indicated, monitor for s/s of constipation, delirium, over sedation, changes in mental status, and reduced respirations. every shift for OPIOID [drug used to reduce moderate to severe pain] use. A review of Resident 1's MAR for the month of February 2025, indicated monitoring for s/s of opioid use was not done on 2/3/25 as physician ordered. A review of Resident 1's Order Summary Report, with start date 1/31/25, indicated, monitor for s/s of dehydration, electrolytes [minerals that help regulate the body's fluid balance], AKI [acute kidney injury], edema [swelling], weight changes, and congestion. every shift for diuretic [medication that increases urine production] use. A review of Resident 1's MAR for the month of February 2025, indicated monitoring for s/s of diuretic use was not done on 2/3/25 as physician ordered. A review of Resident 1's Order Summary Report, with start date 2/19/25, indicated, MIDLINE: Cap Change every shift every shift. A review of Resident 1's MAR for the month of February 2025, indicated midline cap change was not done on 2/27/25 and 2/28/25 as physician ordered. During an interview on 8/20/25, at 2:05 p. m., with the Director of Nursing (DON), the DON confirmed the expectation was for nursing staff to follow physician's orders. During a concurrent interview and record review on 8/21/25, at 1:20 p. m., with Licensed Nurse 3 (LN 3), LN 3 reviewed Resident 1's February 2025 MAR and confirmed Resident 1 had missing dates for Preparation H treatment order, midline monitoring and flushing, monitoring s/s for opioid use, monitoring s/s for diuretic use and changing midline cap changes as physician ordered. LN 3 also reviewed Resident 1's medical chart and confirmed the physician was not notified on those dates and stated the physician was supposed to be notified when a medication or treatment was not given or if monitoring was not done. LN 3 further stated Resident 1 potentially could have had a change of condition or possible infection if monitoring and treatment was not done or documented. LN 3 stated, Anything could happen. could be change of condition. A review of the facility's document titled, Registered Nurse (RN), undated, indicated, Provide nursing services to residents in accordance with scope of practice, facility policies and professional standards of care. Monitor residents for development of acute changes of condition. conduct assessments and notify the provider as needed. Monitor the chronic health conditions of residents. Maintain documentation of all nursing care and services provided to the residents. Administer medications according to practitioner orders and report adverse consequences, side effects or any medication errors. A review of the facility's policies and procedures (P&amp;P) titled, Administering Medications, revised 4/2019, indicated, Medications are</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review, the facility failed to ensure Resident 1 was free from significant medication error when Resident 1 did not receive prescribed antihypotensive medication (used to increase low blood pressure) in accordance with the physician's order. This failure had the potential to result in Resident 1 experiencing low blood pressure and other unnecessary side effects which could have negatively affected Resident 1's health. Resident 1 was originally admitted to the facility in May 2024 with multiple diagnoses which included hypotension (low blood pressure, means that the pressure of blood circulating around the body is lower than normal). A review of Minimum Data Set (MDS, an assessment tool), dated 2/5/25, indicated Resident 1 had impaired cognition. A review of Resident 1's Order Summary Report, with start date 1/31/25, indicated, Midodrine HCl [medication to treat low blood pressure (hypotension)] Oral Tablet 5 MG [milligrams-unit of measurement] (Midodrine HCl) Give 1 tablet by mouth two times a day for hypotension *HOLD for SBP [systolic blood pressure, the top number and refers to the amount of pressure experienced by the arteries while the heart is beating] GREATER THAN 120*. A review of Resident 1's Medication Administration Record (MAR, a legal document used to record medications given to the residents), for the month of February 2025, indicated Resident 1 did not receive the physician prescribed Midodrine medication on 2/1/25, 2/2/15, 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/11/25, 2/12/25, 2/17/25, and 2/20/25 as ordered. During an interview on 8/20/25, at 2:05 p.m., with the Director of Nursing (DON), the DON confirmed the expectation was for nursing staff to follow physician's orders. During a concurrent interview and record review on 8/20/25, at 3:43 p.m., with Licensed Nurse 2 (LN 2), LN 2 reviewed Resident 1's February 2025 MAR and confirmed Resident 1's SPB was lower than 120 and should have received prescribed antihypotensive medication on 2/1/25, 2/2/15, 2/6/25, 2/7/25, 2/8/25, 2/9/25, 2/11/25, 2/12/25, 2/17/25, and 2/20/25 as ordered. LN 2 also reviewed Resident 1's medical chart and confirmed the physician was not notified on those dates and stated the physician was supposed to be notified if a medication was not given. LN 2 further stated Resident 1's blood pressure could have continued to keep dropping and result in Resident 1 having a change of mentation and change in condition. A review of the facility's document titled, Registered Nurse (RN), undated, indicated, Administer medications according to practitioner orders and report adverse consequences, side effects or any medication errors. A review of the facility's policies and procedures (P&amp;P) titled, Administering Medications, revised 4/2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescribed orders, including any required time frame. If a dosage is believed to be inappropriate, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns.</p>		